

BENEFIT PLAN

Prepared Exclusively For
PrideStaff, Inc.

Open Choice PPO HDHP

Extraterritorial
Riders

Aetna Life Insurance Company

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



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Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

Autism spectrum disorder

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

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

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

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

Diabetic drugs and insulin

Important note:

Regardless of tier prescribed, you will not be required to pay more than \$100.00 for a 30 day supply of a covered **prescription** insulin drug.

Pharmacy

All **prescriptions** and refills over a 30 day supply may be filled at a **retail pharmacy** or a **mail order pharmacy**.

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



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

Amendment: Alabama Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

Hearing aids

Hearing aid means:

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

Covered services include prescribed hearing aids and the following hearing aid services and no deductible applies unless this benefit is provided under a qualified High Deductible Plan:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
 - A **physician** certified as an otolaryngologist or otologist
 - An audiologist who:
 - Is legally qualified in audiology
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam. These are limited to no more than 1 per ear every 2 years.
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

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

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

Infertility services

Covered services include seeing a **provider**:

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

Comprehensive infertility services

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

- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination
- Oral and injectable **prescription** drugs used:
 - To stimulate the ovaries
 - Primarily for treating the underlying cause of **infertility**

Infertility covered services may include either dollar or cycle limits. Ovulation induction cycles while on medication to stimulation the ovaries are 6 per lifetime. Artificial insemination cycles are 6 per lifetime. For plans with cycle limits, a “cycle” is defined as:

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

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

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

Aetna's National Infertility Unit

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

The following sentence applies if your plan of coverage includes In and Out of Network Benefits:

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Advanced reproductive technology (ART)

Advanced reproductive technology, also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by an ART **specialist**:

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreservation (freezing), storage for up to 5 years and thawing of embryos, eggs, sperm or reproductive tissue.
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)
- Oral and injectable **prescription** drugs used:
 - To stimulate the ovaries
 - Primarily for treating the underlying cause of **infertility**

ART **covered services** may include either dollar or cycle limits. The ART lifetime maximum is \$15,000. For plans with cycle limits, an ART "cycle" is defined as:

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

You are eligible for other ART services if:

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

Aetna's National Infertility Unit

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

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

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

Covered services for fertility preservation are provided when:

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

Premature ovarian insufficiency

If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

The following are not **covered services**:

- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Nutritional supplements

Eligible health services include formula, medical foods and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria, an inherited disease of amino and organic acids, or inherited metabolic disorder, as defined under Arkansas law.

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

Eligible health services are covered regardless of delivery method, whether enteral or oral, or sole source or supplemental.

Out of network expenses

If your plan includes in-network and out-of-network benefits, out-of-network benefits will always be provided if network services are covered and will be covered with no more than a 25% cost-sharing difference.

Pediatric autoimmune neuropsychiatric disorders

Covered services include diagnosis, evaluation and treatment of pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

Pharmacy

All **prescriptions** and refills up to a 90 day supply may be filled at a **retail pharmacy** or a **mail order pharmacy**

Physical, occupational and speech therapies

Any copayment, coinsurance or deductible, or combination of, that applies to services provided by a licensed physical therapist, occupational therapist or speech-language pathologist, will be no greater than any copay, coinsurance or deductible amount that applies to any office visit to a licensed primary care physician or osteopath.

Prosthetic device

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part
 - Treatment is for a craniofacial disorder such as cleft lip or palate including orthodontic services, dental care, and vision care
 - Treatment is approved by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association in Chapel Hill, NC.
 - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Covered services also include a dehumidifier every 4 years, as deemed **medically necessary** by your **provider**.

Newborn screening for spinal muscular atrophy

The Preventative Care Section of the Schedule of Benefits has been updated to include a Newborn screening for spinal muscular atrophy. These services are reimbursed at 100% no deductible applies.

Newborn children

A newborn child - Your newborn child is covered on your health plan for the first 90 days after birth.

- To keep your newborn covered, we must receive your completed enrollment information within 90 days of birth.
- You must still enroll the child within 90 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
- If you miss this deadline, your newborn will not have health benefits after the first 90 days.

Telemedicine

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

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

The following are not **covered services**:

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

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



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

Amendment: Arkansas Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

Notice

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

When you are injured

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

The difference between a complaint and an appeal

Complaint

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

Appeal

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

Claim decisions and appeal procedures

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

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

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

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

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

Exhaustion of appeal process

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

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

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

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

External review

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

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

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

IRO decisions

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

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

Utilization review

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

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

Recordkeeping

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

Fees and expenses

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

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



Dan Finke

President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Arizona Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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 Palate and Cleft Lip Conditions

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

Services and supplies include:

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

Clinical trials

Routine patient costs

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

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

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

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

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

Early intervention services

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

Covered services include:

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

Maternity and related newborn care

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

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

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

The following are not **covered services**:

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

Nutritional support

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

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

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

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

Vision care

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

Complications of pregnancy

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

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

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

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

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

Telemedicine

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

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

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Colorado Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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.

Precertification

Failure to pre-certify your eligible health services when required will result in a benefit reduction. Covered benefits will never be reduced by more than 50% of the benefits that would have been payable or \$400, whichever is less.

How COB works with Medicare

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



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

Amendment: Connecticut Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Mental health treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **mental disorders**
 - Other outpatient mental health treatment such as:
 - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
 - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications

- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation
- Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Substance related disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**. Treatment of **substance related disorders** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance related disorders** section or unit, unless you are admitted for the treatment of medical complications of **substance related disorders**.
As used here, "medical complications" include, but are not limited to:
 - Electrolyte imbalances
 - Malnutrition
 - Cirrhosis of the liver
 - Delirium tremens
 - Hepatitis
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **substance related disorders**
 - Other outpatient **substance related disorders** treatment such as:
 - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
 - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
 - 23 hour observation
 - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

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

A handwritten signature in black ink, appearing to read 'DF', with a long horizontal line extending to the right.

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

Amendment: Delaware Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Cleft lip and palate

Covered services include treatment for a congenital cleft lip or cleft palate. This includes:

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

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

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

The following are not **covered services**:

- Non-surgical dental services, and therapeutic services related to **jaw joint disorder**

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

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

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

The following has been added to or replaced in the *Eligibility, starting and stopping coverage Who can be a dependent on this plan* section of your booklet-certificate.

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

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



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

Amendment: Florida Medical ET
Issue Date: January 16, 2023

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

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Ambulance/Emergency Services

If your plan includes coverage for expenses related to non-emergency use of the emergency room, those expenses will also apply towards your plan's **maximum out of pocket limit**. If your plan includes coverage for out-of-network expenses, non-emergency ambulance services received from an **out-of-network provider** or other health care provider are paid the same as in-network. If your plan includes coverage for out-of-network expenses and provides coverage related to non-emergency care in a hospital emergency room, those expenses received from an **out-of-network provider** or other health care provider are paid the same as in-network.

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

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

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Georgia Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Eligibility, starting and stopping coverage – Eligibility* section of your booklet-certificate.

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 60 days after the event date.

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Iowa Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Eligibility* section of your booklet-certificate.

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 60 days after the event date.

The following has been added to or replaced in the *General plan exclusions* section of your booklet-certificate:

Abortion

Services and supplies provided for an elective abortion except when the pregnancy places the woman's life in serious danger

Coordination of benefits

Your Coordination of benefits provision has been revised to clarify that “Plan” does not include:

- Hospital indemnity or fixed indemnity coverage
- Accident only coverage
- Specified disease or specified accident coverage
- Limited benefit health coverage
- School accident type coverage
- Benefits for non-medical components of group, long-term care policies
- Medicare supplement policies
- Medicaid policies
- Coverage under other federal governmental plans, unless permitted by law

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



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

Amendment: Idaho Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Introduction* section of your booklet-certificate.

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

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

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Abortion

Covered services include services and supplies provided by a **physician** for an abortion

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Immunizations

Covered services include preventive immunizations for infectious diseases.

Doses, recommended ages and recommended population vary.

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

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Low dose mammography screening, for women age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
 - For women 35-39, a baseline mammogram
 - For women 40 **years** of age and older, annually
 - For women under 40, with a family or prior personal history of breast cancer, positive genetic testing, or other risk factors, at necessary age and intervals
 - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogenous or dense breast tissue, as determined by your **physician**
 - Screening MRI, as determined by your **physician**
- Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your, **Physician**. This includes:
 - Asymptomatic men age 50 and older
 - African-American men age 40 and over
 - Men age 40 and over with family history of prostate cancer
 - Colorectal cancer screening for adults over 50
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings: adults age 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 **years**
- Sigmoidoscopies

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician, PCP, OB, GYN or OB/GYN** for services including annual Pap smears including surveillance tests for ovarian cancer for women at risk for ovarian cancer.
- Preventive care breast cancer (BRCA) gene blood testing
- Clinical breast exams as follows:
 - For women over 20 **years** of age but less than 40, at least every 3 **years**
 - For women 40 **years** of age and older, annually
- Breast cancer chemoprevention counseling
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- HIV screening and counseling for sexually active women
- Osteoporosis screening for women over age 60 depending on risk factors
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Covered services for pregnant women or women who may become pregnant include:

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

Reconstructive breast surgery and supplies

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

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

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part
 - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

The following has been added to or replaced in the *How your plan works, Precertification* section of your booklet-certificate.

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

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**

Step therapy is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

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

Important note:

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

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception to request coverage for a **prescription** drug that is:

- Not covered
- Discontinued (for reasons other than safety or drug manufacturer withdrawal)
- Ineffective in the treatment of your disease or medical condition
- Likely to be ineffective or adversely affect the drug's effectiveness or patient compliance based on:
 - Your known relevant physical and mental characteristics
 - The known characteristics of the drug regimen from a step therapy requirement or dosage limitation

You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours of receipt. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. If the medical exception request is approved by us, you will receive coverage for the **prescription** drug according to the terms of your group policy.

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

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

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **provider** of our decision. In the case of denial, we will provide you with:

- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial.

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate.

Benefit payments and claims

If benefits are not paid within 30 days after proof of loss is received, the **network provider** is entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than \$1 may not be paid.

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



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

Amendment: Illinois Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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.

Questions regarding your policy coverage should be directed to Aetna by calling the toll-free number on your 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 or (317)-232-2395
Complaints can be filed electronically at <https://www.in.gov/idoi>

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your civil union partner who meets any policyholder rules and requirements under state law
- If your plan allows, your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s (if allowed)
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - A child subject to legal guardianship
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
 - If you are either:
 - Younger than age 45, but considered to be at high risk
 - Age 45 or older
- Digital rectal exams (DRE)
 - Younger than age 45, but considered to be at high risk
 - Age 45 or older
- Double contrast barium enemas (DCBE)
 - Younger than age 45, but considered to be at high risk
 - Age 45 or older
- Fecal occult blood tests (FOBT)
 - Younger than age 45, but considered to be at high risk
 - Age 45 or older
- Lung cancer screenings
- Mammograms
 - One mammogram if you are age 35 through 39
 - One mammogram per year if you are either:
 - Younger than age 40, but considered to be at risk
 - Age 40 or older
- Prostate specific antigen (PSA) tests
 - Younger than age 50, but considered to be at high risk
 - Age 50 or older
- Sigmoidoscopies
 - Younger than age 45, but considered to be at high risk
 - Age 45 or older

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



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

Amendment: Indiana Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate:

Autism spectrum disorder

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

Covered services include services and supplies provided by a **provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- You have been diagnosed with cancer and accepted into a phase I, Phase II, Phase III or phase IV clinical trial for cancer
- Your treating **physician** determines that you may benefit from the treatment

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

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

Dental care anesthesia

Covered services include general anesthesia and facility charges for dental care only if you:

- Have a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided
- Are severely disabled, or
- Are under 6 years old

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including obstetrical services for the birth mother of a child you adopt within 90 days of birth. After your child is born, **covered services** include:

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

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

The following are not **covered services**:

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

Off-label use

Covered services may include off-label use of FDA-approved **prescription drugs** when it is not approved for your condition, including cancer. Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition as stated in:
 - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
 - Thomson Micromedex DrugDex System (DrugDex)
 - Clinical Pharmacology (Gold Standard, Inc.) or
 - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
- Use for your condition and the dosage has been proven as safe and effective by at least one well-designed controlled clinical trial, and published in a peer reviewed medical journal known throughout the U.S.
- Your dosage of a drug is equal to the dosage for the same condition as suggested in the FDA-approved labeling or by one of the standard references noted above

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment. We pay oral anti-cancer drugs the same as intravenous (IV) anti-cancer drugs.

The following has been added to or replaced in the *General plan exclusion* section of your booklet-certificate:

Abortion

Services and supplies provided for an elective abortion except to preserve the life of the mother. As used here:

- "Abortion" means the use or **prescription** of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.
- "Elective" means an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed; provided, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date. For birth, adoption or placement for adoption, we must receive a completed enrollment form not more than 31 days after the event date if additional premium for the covered dependent is required

The following has been added to or replaced in the *Eligibility, starting and stopping* section of your booklet-certificate:

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
- 31 days of coverage following the end of your coverage

How you can obtain other coverage after your group coverage ends

When your group health plan ends, you may be eligible to apply for comprehensive guaranteed issue coverage through an individual policy inside or outside the Health Insurance Marketplace:

- At the termination of employment
- The subscriber is retired or pensioned
- When loss of coverage under the group plan occurs
- When loss of dependent status occurs
- At the end of the maximum health coverage continuation period
- You are no longer in an eligible class

Application and payment of the initial premium for such individual policy should be consistent with the terms described in the respective policy chosen by you. Contact us to learn about other insurance coverage options available to you.

Converting from a group to an individual health plan

When your group health plan ends, you may be eligible to change to an individual health plan.

When are you eligible for a conversion plan?

You are eligible if:

- You had group health coverage under this plan continuously for the last 3 consecutive months before your coverage ended, and
- Your COBRA coverage has ended and you aren't eligible for additional extensions

You are not eligible if:

- You did not pay your premium contributions under this plan.
- This plan ends because the contract between the group and us ends and is replaced by another group plan within 31 days.
- You are eligible for health coverage under another group plan.
- You are eligible for Medicare coverage, whether or not you have actually enrolled in Medicare.
- You are already covered under an individual health plan.

How you apply for a conversion plan

To apply:

- We must receive your application and your first premium payment within 45 days after your group plan ends.

The following has been added to or replaced in the *Glossary* section of your booklet-certificate.

Telemedicine

A consultation between you and a **physician, specialist, or behavioral health provider, or telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Kansas Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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.

Hospice care

This plan will meet or exceed Medicare's hospice benefit. No **coinsurance** or **copayments** will apply. No **deductible** will apply unless this benefit is provided under a Qualified High Deductible Plan. There are no per visit or dollar limits that apply.

Coordination of benefits

Some people have health coverage under more than one health plan. If you are covered by more than one health benefit plan, you should file all your claims with each plan. We will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

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

Allowable expense means a health care expense that any of your health plans cover.

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

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Provider sponsored integrated health delivery network
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group
- Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA
- Any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky and does not include policies listed below.

The definition of a plan does not include:

- No fault contracts and traditional automobile "fault" contracts
- Student accident only insurance
- Any health benefit plan as specified by Kentucky state law

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
 - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
 - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
 - The amount that the secondary plan saved due to COB
 - Used to cover any unpaid allowable expenses
 - Erased at the end of the year

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



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

Amendment: Kentucky Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate:

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance service

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport
- For your newly born child and disabled mother to a **hospital** or neonatal unit

Non-emergency

Covered services also include precertified transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment
- For your newly born child and disabled mother to a **hospital** or neonatal unit

For the purpose of this benefit:

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

The following are not **covered services**:

- Non-emergency airplane transportation by an **out-of-network provider**
- Ambulance services for routine transportation to receive outpatient or inpatient services

Autism spectrum disorder

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

Covered services include services and supplies provided by a [**physician**] or **behavioral health [provider]** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Cleft lip and cleft palate

Covered services include the treatment and correction of cleft lip and-palate. This coverage shall include benefits for secondary conditions and treatment attributable to that primary medical condition. **Covered services** include services and supplies:

- Oral and facial **surgery**, including care by a **physician** before and after **surgery**
- Prosthetic treatment such as:
 - Obturators
 - Speech appliances
 - Feeding appliance
- Orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health
- Adequate dental structures for orthodontic treatment
- Prosthetic management or therapy
- Speech-language evaluation and therapy
- Audiological assessments and management
- Otolaryngology treatment
- Psychological assessment and counseling
- Genetic assessment and counseling for you, your dependent child and the child's parents

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

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

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or other life-threatening disease or condition.

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

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

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

COVID-19 services

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

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

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

- Diagnostic test
- Antibody test

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due to either age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

Diabetic services, supplies, equipment, and self-care training and education programs

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles and pens
 - Test strips - blood glucose, ketone and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Self-management training and education provided by a health care **provider** certified in diabetes self-management training, including medical nutrition therapy

Hearing aids and exams for minors

Eligible health services include hearing care for children through age 25 that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

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

The following are not **covered services**:

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

Jaw joint disorder treatment

Covered services include the diagnosis, therapeutic services and surgical treatment of **jaw joint disorder** by a **provider**, including:

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

The following are not **covered services**:

- Non-surgical medical and dental services related to **jaw joint disorder**

Nutritional support

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

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not **covered services**:

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

Mail order pharmacy

For certain kinds of **prescription drugs**, you can use the plan’s **network mail order pharmacy**. Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy** or a CVS/pharmacy®. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn’t approved by the FDA for this treatment. We pay oral and anti-cancer drugs the same as intravenous (IV) anti-cancer drugs.

Prosthetic devices and services

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

Prosthetic device means:

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

Coverage includes:

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

Reconstructive breast surgery and supplies

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

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

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician, PCP** (if applicable to your plan), OB, GYN or OB/GYN for services including annual Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Coverage is not subject to a deductible for network or out-of-network providers, if applicable to your plan..

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Digital rectal exams (DRE)
- Lung cancer screenings
- Mammograms including diagnostic imaging and ultrasound screening designed to evaluate an abnormality
- Prostate specific antigen (PSA) tests*

Important note:

*Prostate cancer screening includes a second visit when **medically necessary** and follow-up treatment within sixty days after either visit, if related to a condition diagnosed or treated during the visits.

If you need a routine gynecological exam performed by a as a part of a cancer screening, you may go directly to a **network provider** (if applicable to your plan) who is an OB, GYN, or OB/GYN without a referral.

Telemedicine

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

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

The following are not **covered services**:

- Telephone calls, except if after access and review of the patient's medical records, the **physician, specialist, behavioral health provider** or other **telemedicine provider** decision meets the same standard of care as if the healthcare services were provided in person
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Treatment of metastatic or unresectable tumors

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

Important note

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

Translation charges

Covered services include services for translation charges for a qualified interpreter/translator related to covered medical treatment or diagnostic consultations performed by a **physician**. This is available to you if the services are required because you are deaf, hard of hearing, have a hearing loss or you cannot understand or communicate in spoken language. The interpreter/translator cannot be a family member.

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate:

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

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

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

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

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

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

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

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

Therapies and treatments including:

- If you:
 - Move out of the geographic service area of the Plan
 - Choose to change **provider**
 - Requires only routine monitoring for a chronic condition but is not in an acute phase of the health condition
- If the **provider**:
 - Moves out of the geographic service area of the Plan
 - Does not consent to continue to provide services

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

Step therapy

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

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

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

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

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

Requesting a medical exception

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

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

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

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

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, or someone who represents you or your **prescriber** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker medical exceptions in urgent situations, we will tell you, or someone who represents you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Coordination of benefits

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

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The plan that pays after the Primary plan is Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total.

Key Terms

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

Allowable expense means a **covered service**, including **deductibles**, **coinsurance** and **copayments**, that are covered in full or at least in part by any Plan covering the person. Where a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and will be paid.

Claim determination period or plan year:

- A period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefit payable in the absence of COB to determine whether over-insurance exists and how much each plan will pay or provide:
 - The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group or individual contact. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period
 - As each claim is submitted, each plan determines its responsibility and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination.

Closed panel plan(s) means:

- A plan that provides **covered services** to covered persons primarily in the form of services through a participating **provider** and that excludes coverage for services provided by non-participating **providers**, except in cases of emergency or referral by a **provider**.

Custodial parent means:

- The 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 excluding any temporary visitation.

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

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Closed panel plans or other forms of group or group type coverage (whether insured or not insured)
- Medical care components of long-term care contracts, such as skilled nursing care
- Group and non-group coverage through closed panel plans
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medical benefits under a group or individual automobile insurance policy
- Medicare or any other federal government plan, as permitted by law
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

A plan does not include:

- Hospital indemnity coverage
- Accident only
- Specified disease or specified accident coverage
- Limited benefit health coverage, as defined by law
- School accident type coverage
- Benefits for non-medical components of group, long-term care policies
- Medicare supplement policies
- Medicaid policies
- Coverage under other federal governmental plans, unless permitted by law

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

How COB works

- When this is the primary plan, we pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, adds up to more than 100% of the allowable expenses
- When this is your secondary plan:
 - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
 - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

Any plan that does not contain your state’s COB provision is always the primary plan pursuant to Regulation 32 COB Model.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan:
 - Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.
 - Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by 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 by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- Each plan determines its order of benefits using the first of the following that apply:

COB rule if you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee , retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Exception to the rule above when you are a Medicare beneficiary	If you or your spouse is a Medicare beneficiary: <ul style="list-style-type: none"> • And as a result of federal law, Medicare is secondary to the plan covering you or your spouse 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 or retired employee is the secondary plan and the other plan is the primary If you have any questions about this you can contact us: <ul style="list-style-type: none"> • See the section How COB work with Medicare below. 	Same rule under primary plan

COB rule if you are covered as a:	Primary plan	Secondary plan
	<ul style="list-style-type: none"> • Online: Log on to your secure member website at www.aetna.com. • Select Find a Form, then select Your Other Health Plans. • By phone: Call the toll-free number on your ID card. 	
Child – of parents married or living together, whether or not they have ever been married	<p>Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule*)</p> <p>*Same birthdays – the plan that has covered a parent longer is primary</p>	<p>Plan of parent whose birthday* is later in the year</p> <p>*Same birthdays – the plan that has covered a parent longer is primary</p>
<p>Child of:</p> <ul style="list-style-type: none"> • Parent separated, divorced, or not living together, whether or not they have been married and the plan of that parent has actual knowledge of the terms, that plan is primary • With court-order will apply to plan years beginning after the plan has given notice or the court-order 	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in the court order • If that parent has no coverage then their spouse’s plan is primary 	<ul style="list-style-type: none"> • Plan of other parent • If the parent has no coverage then their spouse’s plan is primary
<p>Child of:</p> <ul style="list-style-type: none"> • Parent separated, divorced, or not living together, whether or not they have been married court-order states both parents are responsible for coverage or have joint custody where the court did not state that one parent is responsible 	<p>Primary coverage is based on the birthday rule</p>	<p>Secondary coverage is based on the birthday rule</p>

COB rule if you are covered as a:	Primary plan	Secondary plan
Child of: Parents separated, divorced, or not living together, whether or not they have been married and there is no court-order that states which parent is responsible for health coverage	The order of benefits payment is: <ul style="list-style-type: none"> • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last 	See rule under Primary plan
Child – covered under: More than one plan by an individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when the when making the order of benefits determination: See all “Child of” content above	Same rule as Primary plan
Child covered by the spouse’s plan: is: <ul style="list-style-type: none"> • When the child has health coverage under either or both parents’ plans and also has health coverage for a dependent under the spouses’ plan 	See “Longer or shorter length of coverage” shown below	Same rule as Primary plan
Child covered by the spouse’s plan: is: <ul style="list-style-type: none"> • In the event the child’s health coverage under the spouse’s plan began on the same date as the health coverage under either or both parents’ plan 	Primary and secondary coverage is based on the birthday rule of the child’s parent or spouse See “Child of” content above	Same rule as Primary plan
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree) is primary or to COBRA or under a state or other Federal	COBRA or state or other Federal continuation coverage If the other plan does not

COB rule if you are covered as a:	Primary plan	Secondary plan
	<p>continuation of coverage</p> <p>If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applied</p>	<p>have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applied</p>
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	<p>If none of the above rules apply, the plans share the allowable expenses equally between the plans meeting the definition of “plan” shown in the “key terms” above</p> <p>This plan will not pay more than it would had it been the primary plan</p>	<p>If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applied</p> <p>This plan will not pay more than it would had it been the primary plan</p>

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved
Secondary plan	<ul style="list-style-type: none"> • Effect of the benefits when the plan is secondary: • It may reduce its benefits so that the plans during a year are not more than the total allowable expenses • In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan • May then reduce its payment by the amount 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 the total allowable expense for that claim • Shall credit to its plans deductible, coinsurance, copayments and any amount it would have credited to its deductible in the absence of other health care coverage • It may reduce its benefits so that the total

	<p>benefits paid or provided by all plans during a plan year or claim determination period are not more than 100% of total allowable expenses</p>
<p>Benefit reserve*</p>	<p>The benefit reserve when this plan is the secondary plan:</p> <ul style="list-style-type: none"> • Is the difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period • As each claim is submitted will determine: <ul style="list-style-type: none"> – Its responsibility to pay or provide benefits under its contract – Whether a benefit reserve has been recorded for the covered person – Whether there are any unpaid allowable expenses during that claims determination period <p>Will use the covered person's benefit reserve to pay up to 100% of the total allowable expenses incurred during the claim determination period</p> <p>At the end of the claims determination period, the benefit reserve returns to zero</p> <p>A new benefit reserve must be created for each new claim determination period</p>

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel **provider**, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plan.

*Note: You may request a paper copy or electronic form of an Appendix C. It will provide you with an explanation for secondary plans:

- The purpose and use of the benefit reserve
- How secondary plan calculate claims

You can request a copy of the Appendix C by contacting us:

- Online: log on to your secure member website at www.aetna.com
- By phone: Call toll-free number on you ID card

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

If you are a Medicare beneficiary, the plan coordinates benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

You are a Medicare beneficiary if you are covered under it by reason of age, disability or end stage renal disease. With respect to Medicare part B, even if you are not covered because you refused it, dropped it, or didn't make a request for it.

If you have Medicare because of:

End stage renal disease (ESRD)	Your plan will pay first for the first 30 months Medicare will pay first after this 30 month	Medicare Your plan
A disability other than ESRD and the policyholder has more than 100 employees	Your plan	Medicare

Note regarding ESRD: If you are already a Medicare beneficiary due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this will be secondary.

This plan is secondary to Medicare in all other circumstances.

Who pays first?

We are primary	We pay your claims as if there is no Medicare coverage
Medicare is primary	We calculate our benefits as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is not more than 100% of the allowable expenses

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

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Other health coverage updates – contact information

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

Right to receive and release needed information

There are certain facts about your health coverage and services that are needed to:

- Apply COB rules
- Determine benefits payable under this plan or other plans

We may get the facts we need from or give them to other plans or persons for the purpose of:

- Applying these rules
- Determining benefits that will be paid from the plan covering you or your family member claiming benefits under this plan and other plans covering the person claiming benefits.

We do not need to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply those rules and determine benefits payable.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When this happens, we will pay your plan benefit to the other plan. That amount will be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services. In which case, “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

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

- One or more of the persons we paid or for whom we paid
- Any other person or plan that may be responsible for the services provided for the covered person under these COB rules

The “amount of the payment made” includes the reasonable cash value of any benefits provided in the form of services.

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures and does not change or replace the language contained in the certificate which determines your benefits.

Double coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both **employers**. When you are covered by more than one health plan, state law allows your insurers to follow coordination of benefits procedure to determine how much each plan pays when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses. Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. Read your contract carefully. If your situation is not described, contact your state insurance department.

Primary or secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine where we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim.

A plan that does not contain your states COB rules according to Regulation 62 COB Model will always be primary.

When this plan is primary

If you or a family member are covered under another plan in addition to this one, we will be primary.

When we will be primary, see the chart under “Determining who pays” for:

- Your own expenses
- Your spouse’s expenses
- Your child’s expenses

Other situations

We will be primary when any other provisions of state or federal law require us to be.

How we pay claims when we are primary

When we are the primary plan, we will pay the benefits in accordance with the terms in your certificate just as if you had no other health care coverage under any other plan.

How we pay claims when we are secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan; we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a health care service or expense covered by one of the plans, including **copayments, coinsurance** and **deductibles**.

- If there is a difference between the amount the plans allow, we will base our payments on the higher amount. However, if the primary plan has a contract with **provider**, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider (PPOs) usually have contracts with their **providers**.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefits because you did not obtain pre-authorization, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.
- Benefit reserve
- When are secondary we often will pay less than we would have paid if we had been primary. Each time we “save” by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the saving. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year for each balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?

Contact your state insurance department

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate:

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 2 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision as soon as possible but not less than 24 hours for an urgent request, or 72 hours if clinical information is required and received more than 24 hours after request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

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

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

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

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

Authorized representative

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

Grievance

A grievance is a type of written or oral complaint, it may involve an urgent care request on your behalf. about any of the following:

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

You or your provider can call the toll-free number on the back of your ID card or write Member Services at P.O. Box 14462 Lexington, KY 40512 to let us know about your grievance.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. [If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide.] You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay a paper claim within 45 days and an electronic claim within 25 days from when we received all of the information necessary. When a paper claim is submitted 45 days after the date of service, we will pay that claim within 60 days. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and, appeal procedures* section for that information.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
 - To be eligible for coverage, a domestic partner is a person who certifies the following as of the date of enrollment:
 - He or she is your sole domestic partner and intends to remain so indefinitely
 - He or she is not married or legally separated from anyone else
 - He or she is not registered as a member of another domestic partnership within the past 6 months
 - He or she is of the age of consent in your state of residence
 - He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
 - He or she has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabit and reside with you indefinitely
 - He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
 - He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage
 - He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
 - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
 - Common ownership of a motor vehicle
 - Driver's license with a common address
 - Proof of joint bank accounts or credit accounts
 - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
 - Assignment of a durable property power of attorney or health care power of attorney.
- Dependent children – yours or your spouse's or partner's
 - Dependent children must be under age 26, and they include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody
 - A grandchild whose parent is already covered as a dependent on this plan
 - Any child placed in your home due to the execution of an act of voluntary surrender

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

To enroll an out of area dependent on this plan (if applicable to your plan):

- You must be enrolled as an **employee** in a different Aetna plan option offered by the **policyholder**
- Your eligible dependent must live outside your plan's service area

The following has been added to or replaced in the *Complaints, claim decisions and appeal procedures* section of your booklet-certificate:

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

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

Appeal

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

Claim decisions and appeal procedures

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

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer for a level 1 and 2 within 36 hours. We will also give you an answer within 15 calendar days for a level 1 pre-service appeals and within 5 days for a level 2 pre-service appeal. A concurrent claim appeal will be addressed 2 days after the adverse determination.

Any other claim appeal

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

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

You can appeal two times under this plan. We call these a level 1 and level 2 appeal. If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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

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

You may also call the toll-free number 1-800-259-5300 or visit LDI website at www.lidi.la.gov.

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

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

Exhaustion of appeal process

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

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

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

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

External review

External review is a review done by people in an organization outside of Aetna. This is called an Independent review organization (IRO). The types of External reviews are:

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

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

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

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

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

- To Aetna
- At the time that you received the decision from Aetna of an adverse determination or final adverse determination, when you are requesting an expedited external review
- Within 4 months of the date you received the decision from us notice of the decision Aetna of an adverse determination or final adverse determination, when you are requesting a standard external review or a standard or expedited external review for experimental or investigational treatment
- With a copy of the notice from us, along with any other important information that supports your request

Upon request and free of charge, we will provide you with copies of all documents about your claim. We will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

Aetna will :

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

The IRO will:

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

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

How long will it take to get an IRO decision?

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

Sometimes you can get an expedited external review decision. You or Your authorized representative must call us or send us a request for external review form.

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

For initial adverse benefit determinations

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

For final adverse determinations

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

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

Timeframes for external review decisions

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

Type of external review	When we complete a preliminary review of the request and notify you	When the review request is assigned to the IRO	When the IRO completes their review and notifies you
Standard external review	Within 5 days	Within 1 business day after receiving request from Aetna	Within 45 days after the date of receipt of the request
Expedited external review (oral or written)	Immediately after receiving request	Immediately after receiving request from Aetna	As soon as possible but no longer than 72 hours after getting assigned
Standard external review of experimental or investigational treatment adverse determination	Within 5 business days after receiving request to determine eligibility	Within 1 business day after the date of receiving request from Aetna	Within 20 days after the date it receives the opinion of each clinical peer to make a decision (clinical peers have 20 day to provide a written opinion to IRO)
Expedited review of experimental or investigational treatment adverse determination	Immediately after receiving request	Immediately after receiving request from Aetna	<p>As soon as possible but no longer than 8 days after receipt of assignment</p> <p>The decision may take up to 8 days because the: IRO has 1 day after receiving the request to assign the review to clinical review</p> <p>Clinical peers shall provide an oral or written opinion to the IRO as soon as possible but no longer than 5 days of being assigned</p> <p>IRO has 48 hours after the date it receives the opinion of each clinical peer to make a decision</p>

Utilization review

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

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

Recordkeeping

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

Fees and expenses

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

The following has been added to or replaced in the *General provisions – other things you should know* section of your booklet-certificate:

When you are injured

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

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

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

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

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Louisiana ET Rider

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

Interpreter and translation services

TTY: 711

To access language services at no cost to you, call 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician profiling

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

Maximum coinsurance differential for network plans

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

Clinical trials

Routine patient costs

Covered services include routine patient costs or “patient care services” you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

“Patient care services” means a healthcare item or service that is given to you for being enrolled in a qualified clinical trial that:

- Is consistent with the usual and customary standard or care for someone with your diagnosis
- Is consistent with the study protocol for the clinical trial
- Would be covered if you did not participate in the clinical trial

The following are not **covered services**:

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

Covered equipment under the Diabetic services, supplies, equipment and self-care programs benefit also include foot orthotic devices including orthopedic shoes and inserts.

Early intervention services

These are services delivered by a qualified early intervention service **provider** as described under Part C of the Individuals with Disabilities Education Act. They are available for children from birth to age 3 who are eligible for these services.

Covered services include:

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

Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Infertility services

Basic infertility

Covered services include seeing a **provider**:

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

Comprehensive infertility services

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

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

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

- You or your partner have been diagnosed with **infertility**
- You have met the requirement for the number of months trying to conceive through egg and sperm contact

Aetna's National Infertility Unit

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

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Advanced reproductive technology (ART)

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

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Intracytoplasmic sperm injection (ICSI).
- Sperm, egg and/or inseminated egg procurement and processing, or banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
- Cryopreservation (freezing) of eggs
- Assisted hatching
- Storage for up to 5 years and thawing of eggs, embryos, sperm or reproductive tissue.
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

You are eligible for ART services if:

- You or your partner have been diagnosed with **infertility**
- You have exhausted comprehensive **infertility** services benefits or have a clinical need to move on to ART procedures
- You have met the requirement for the number of months trying to conceive through egg and sperm contact

Aetna's National Infertility Unit

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

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

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

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
 - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
 - Other gonadotoxic therapies
 - Removing the uterus
 - Removing both ovaries or testicles

Premature ovarian insufficiency

If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

The following are not **covered services**:

- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Maternity and related newborn care

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

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

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

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

The following are added to Key Terms within Coordination of benefits.

- MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy.
- PIP means the personal injury protection coverage included in a motor vehicle liability policy.

The following rule is added as the first rule to apply in Determining who pays within Coordination of benefits.

COB rule	Primary Plan	Secondary plan
A motor vehicle policy and are injured as a result of an accident with a motor vehicle	PIP is the primary plan for the first \$2,000 of expenses. After that, plans will coordinate benefits in accordance with these COB provisions.	The plan which is not a motor vehicle policy

How do you extend coverage if you leave your job

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

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

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

How do you extend coverage if your plant closes

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

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

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

How do you extend coverage for a former spouse

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

Benefits will end on the earliest of:

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

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

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

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Massachusetts Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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.

Habilitation therapy services

Habilitation therapy services are services and devices, including occupational therapy, physical therapy and speech therapy, that help you keep, learn or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). You are covered up to at least age 20. The services must follow a specific treatment plan, ordered by your **physician**. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy
- Occupational therapy
- Speech therapy (speech function is the ability to express thoughts, speak words and form sentences)

The following are not **covered services**:

- Services provided in a training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis.

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

- Systematically change behavior
- Are responsible for observable improvements in behavior

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the International Classification of Diseases, Tenth Edition (ICD-10).

Covered services include services and supplies provided for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Maryland Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

Elective Abortions

Elective abortions are only eligible for coverage if the procedure is necessary to preserve the life of the mother.

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



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

Amendment: Michigan Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Autism spectrum disorder

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

Covered services include services and supplies provided by a physician or behavioral health provider for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder
- Neurodevelopmental and behavioral health treatments and management

Cleft lip and cleft palate

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

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

Under this provision, if orthodontic treatment services are eligible for coverage under a dental insurance plan and this plan, the dental plan is primary and this plan is secondary.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial”

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

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

Dental care anesthesia

Covered services include anesthesia if you:

- Are a child under age 5
- Are severely disabled
- Have a medical condition and requires hospitalization or general anesthesia for dental care treatment

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** under this certificate.

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

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles and pens
 - Test strips - blood glucose, ketone and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training, including medical nutrition therapy

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

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

Your plan only covers the same type of DME that Medicare covers. But, there are some DME items Medicare covers that your plan does not.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Hearing aids for a covered person age 18 and under

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Home health care

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

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

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are ventilator dependent, **covered services** also include 120 hours of services by a home care nurse or personal care assistant during the time you are in a **hospital**, to serve as your communicator or interpreter with **hospital** staff.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

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

The following are not **covered services**:

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

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product

The following are not **covered services**:

- All services and supplies provided in:
 - Rest homes
 - Any place considered a person's main residence or providing mainly custodial or rest care
 - Health resorts
 - Spas
 - Schools or camps

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

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

Lyme disease treatment

Covered services include treatment of diagnosed Lyme disease.

Nutritional support

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

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not **covered services**:

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

Pediatric streptococcal conditions

Covered services include services related to the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute onset neuropsychiatric syndrome (PANS) including:

- Behavioral therapies to manage neuropsychiatric symptoms
- Plasma exchange
- Immunoglobulin
- Antibiotics and medications

Medications are considered **covered services** under the *Prescription drugs-outpatient* provision.

Port wine stain elimination

Covered services include services for elimination or maximum feasible treatment of port wine stains.

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn’t approved by the FDA for this treatment.

For prescription drugs covered under this provision, for which certification was received, we will not impose a higher **deductible, copayment** or **coinsurance** not applied to **prescription drugs that are used to kill or slow the growth of cancerous cells**.

Anti-psychotic prescription drugs

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

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

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

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

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

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

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

In order to be eligible for continuity of care:

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

The continuing care benefit will be extended annually when:

- The prescriber re-indicates dispensed as communicated
- Renews the certification with us

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

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

Prosthetic devices

A prosthetic device is

- a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects
- A scalp hair prosthesis worn for hair loss as a result of alopecia areata.

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

Coverage includes:

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

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms - includes digital breast tomosynthesis for a person **at risk for breast cancer**
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
- Surveillance tests for ovarian cancer for women **at risk for ovarian cancer**- includes
 - CA-125 serum tumor marker testing
 - transvaginal ultrasound
 - pelvic examination
 - other proven ovarian cancer screening tests currently being evaluated by the Food and Drug Administration or the National Cancer Institute

*Screenings for men age 40 or over who are symptomatic or in a high-risk category and for all men age 50 or older.

Reconstructive surgery and supplies

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

- Your **surgery** is needed to correct an injury incidental to or following **surgery** resulting from injury of the involved body part
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in facial disfigurement or functional impairment of a body part
 - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in facial disfigurement or functional impairment of a body part, and your **surgery** will improve function.
- Your covered dependent child's **surgery** is needed due to a congenital disease or anomaly which resulted in functional defect, as determined by their **provider**.

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate.

Surprise Bill

There may be times when you unknowingly receive services or do not consent to receive services from an **out-of-network provider**, even where you try to stay in the network for your covered services. You may then get a bill at the **out-of-network** rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider**, including independent freestanding emergency departments. Your final diagnosis will not determine whether services are **emergency services**.
 - Your coverage for **emergency services** will continue until you are evaluated and your condition is stabilized and:
 - Your attending **physician** determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another **provider** if you need more care
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at an in-network facility, except when the non-participating provider has satisfied the notice and consent criteria for **out-of-network** cost shares by:
 - Providing **out-of-network** notice to you of the estimated charges for the items and services and that the **provider** is a non-participating provider
 - Obtaining consent from you to be treated and balance billed by the non-participating **provider**.
 - Providing written notice and obtaining consent within 72 hours of the item or service being delivered or, if the item or service is scheduled within that timeframe, at the time the appointment is made.

Surgical or ancillary services mean any professional services including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

A facility in this instance means an institution providing health care related services or a health care setting, including **hospitals** and other licensed inpatient centers; ambulatory surgical or treatment centers; **skilled nursing facilities**; **residential treatment facilities**; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

Any cost-sharing requirement for the items and services will be calculated based on the recognized amount which for surprise bill protection is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.

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

Contact us if you receive any surprise bills or have any questions regarding what constitutes a surprise bill.

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 5 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

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

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

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Recission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren
 - A grandchild whose parent is already covered as a dependent on this plan

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

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

Your coverage may be extended if you are totally disabled when coverage ends. You are “totally disabled” if you cannot work at your occupation within the first 2 years of your disability or you cannot work at your own occupation or any other occupation for pay or profit after 2 years of disability.

Your covered dependent is “totally disabled” if that person is incapable of self-sustaining employment due to developments disability, mental or physical disability and depends mainly on you for support and maintenance.

You may extend coverage until the earliest of:

- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan

How your dependent can extend coverage after you die

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 31 days after your death, and
- Payment is made for coverage

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

- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan

Premium for this extended coverage will not exceed 102% of the cost of the plan for other similarly situated dependents who are not survivors or a deceased insured.

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

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

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

You and your dependents coverage will end on the earliest date:

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

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

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

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

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

Premium for this extended coverage will not exceed 102% of the cost of the plan for other similarly situated dependents

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

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

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

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

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

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

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

- The end of the 36 month period after the date you enroll in Medicare
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop

Premium for this extended coverage will not exceed 102% of the cost of the plan for other similarly situated dependents.

The following has been added to or replaced in the *General provisions – other things you should know* section of your booklet-certificate.

When you are injured

The following will only apply after you received a full recovery from another source. Full recovery does not include payments made by a health plan to or for your benefit.

If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money from a third party. If you receive a full recovery from another source, we may be entitled to be reimbursed from that source for amounts we have paid for your care. We have that right of reimbursement no matter what source the money comes from – for example, the other driver, the policyholder, or another insurance company. Our right to be reimbursed will be offset by monies paid to account for the pro rata share of your costs, expenses, and reasonable attorney’s fees you spend to obtain your recovery from another source.

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

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

The following has been added to or replaced in the *Glossary* section of your booklet-certificate.

At risk for breast cancer

At risk for breast **cancer** is any of the following:

- Having a family history with one or more first or second degree relatives with breast cancer
- Testing positive for BRCA1 or BRCA2 mutations
- Having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology
- Having a previous diagnosis of breast cancer.

At risk for ovarian cancer

At risk for **ovarian cancer** is any of the following:

- Having a family history:
 - With one or more first or second degree relatives with ovarian cancer
 - Of clusters of women relatives with breast cancer
 - Of nonpolyposis colorectal cancer
- Testing positive for BRCA1 or BRCA2 mutations

Child health supervision

Appropriate services for a child from birth to age 6, including:

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

Child health supervision age ranges and frequency are:

- Birth to 12 months, at least 5 visits
- 12-24 months, 3 visits
- 24-72 months, 1 per year

Child health supervision also includes immunizations as appropriate for a child from age 6 to 18, as defined by the Standards of Child Health Care issued by the American Academy of Pediatrics.

Jaw joint disorder

This is:

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

Medically necessary, medical necessity

Health care services that we determine a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing restoring, maintaining, or treating an **illness, deterioration, injury**, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease

Generally accepted standards of medical practice mean:

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

Telehealth

A consultation between you and a **physician, specialist, or behavioral health provider, or telehealth provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

The following has been added to or replaced in your booklet-certificate.

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

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

A handwritten signature in black ink, appearing to read 'DF', with a long horizontal line extending to the right.

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

Amendment: Minnesota Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

Retail Pharmacy

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

Timely payment of claims

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

A clean claim does not include any other the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or
- d. Claims submitted by a provider more than thirty (30) days after the date of services; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

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

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

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

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

Payment of claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the **provider**, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

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

Appeal

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

Claim decisions and appeal procedures

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

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

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

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

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

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

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

External review

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

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

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

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

You must submit the request for external review form:

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

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

The ERO will:

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

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

How long will it take to get an ERO decision?

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

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

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

For initial adverse benefit determinations

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

For final adverse determinations

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

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

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

Utilization review

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

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

Recordkeeping

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

Fees and expenses

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

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Mississippi Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

Your group policy has changed. The booklet-certificate is revised to reflect this. This change is effective on the date shown above.

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate

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

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles and pens
 - Test strips - blood glucose, ketone and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
 - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Hearing aids

Hearing aid means:

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

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

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
 - A **physician** certified as an otolaryngologist or otologist
 - An audiologist who:
 - Is legally qualified in audiology
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Replacement of a hearing aid and associated services within 3 months if:
 - The gain and output fail to meet the prescribed targets
 - It is unable to be repaired or adjusted
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

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

Anti-cancer drugs taken by mouth, including chemotherapy drugs and drugs to treat human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)

Covered services include any drug prescribed for cancer treatment, HIV or AIDS. The drug must be recognized for treating cancer, HIV or AIDS in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Preventive care immunizations

No deductible applies to immunizations for dependent children to age 6.

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms, including:
 - One baseline mammogram for women between ages 35 and 40
 - One mammogram every 2 years for women between ages 40 and 49
 - One mammogram every year for women age 50 and older
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

The following has been added to or replaced in the *Complaints, claim decisions and appeal procedures* section of your booklet-certificate.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

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

Claim decisions and appeal procedures

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

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete the first level before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 15 calendar days for a post-service claim.

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

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

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

Exhaustion of appeal process

In most situations, you must complete the first level of appeals with us before you can take these other actions. The second level of appeal is always voluntary:

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

You may contact the Nebraska Department of Insurance at any time during the claim process with a complaint.

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

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

External review

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

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

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

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

You must submit the request for external review form:

- To the Nebraska Department of Insurance
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Nebraska Department of Insurance will:

- Contact the IRO that will conduct the review of your claim
- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review

The IRO will:

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

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

How long will it take to get an IRO decision?

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

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

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

For initial adverse benefit determinations

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

For final adverse determinations

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

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

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

Utilization review

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

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

Recordkeeping

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

Fees and expenses

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

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Nebraska Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Civil union partners

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

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

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



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

Amendment: New Jersey Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate.

Claim Determinations

A. Claims.

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

B. Notice of Claim.

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

C. Timeframe for Filing Claims.

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

D. Claims for Prohibited Referrals.

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

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

- 1.** A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination [or Referral]), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim. If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.
- 2. Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

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

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

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



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

Amendment: New York Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. This would include coverage of **injury** or sickness and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier. The decision can be made by a certified nurse-midwife in collaboration with the attending **physician**.

Precertification is only required for maternity and newborn **stays** that exceed the standard length of **stay**.

If the mother is discharged earlier, **covered services** include post-delivery home visits for follow-up care for the mother and newborn when recommended, ordered and supervised by a health care **provider**, which includes a **physician** or advanced practice registered nurse. If the mother is discharged earlier than the minimum lengths of **stay**, **covered services** include all follow-up care received within 72 hours after discharge. If the mother receives at least the minimum number of hours of inpatient care, we will pay for **covered services** as recommended by the attending **physician**. The home visits include:

- Parent education
- Assistance training in breast or bottle feeding
- Physical assessment of the newborn and mother
- The collection of an adequate sample for the hereditary and metabolic newborn screening
- Clinical tests and other services that are in line with follow-up care recommended in the protocols and guidelines developed by national organizations representing the **providers**

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries
- Surrogacy when the surrogate is not a covered person

The following has been added to or replaced in the Adding New Dependents subsection within the *Eligibility, Starting and Stopping Coverage* section of your booklet-certificate.

Your newborn child is covered on your health plan for the first 31 days from the moment of birth at no cost.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Continuation of coverage - State of Ohio

Your rights

Ohio law gives some people the right to keep their health coverage for 12 months after active employment ends. To be eligible for this coverage:

- You must have been employed for three consecutive months immediately before coverage ended
- You could not have voluntarily ended your employment
- Your employment could not have ended for gross misconduct
- You cannot be covered or eligible for any other group plan, Medicare, or COBRA

When I will receive continuation information

The chart below lists who is responsible for providing notice, the type of notice, and the timing.

Employer/Group health plan notification requirements

Notice	Requirement	Deadline/method
General notice - Aetna	Notice to you and your dependents of continuation rights	By this certificate
Notice of qualifying event – employer	Your active employment ends for reasons other than gross misconduct	When your employer notifies you that your employment has ended

How to enroll

You enroll by sending an application and paying the premium to your employer. The application will tell you how to enroll and how much it will cost.

When your first premium payment is due

Your first premium payment must be made:

- Within 31 days after your coverage ends
- Within 10 days if your employer notified you that your employment has ended before your coverage termination date
- Within 10 days if your employer notified you of your right to continue coverage after your coverage would have terminated

How much coverage will cost

You and your dependents will pay a monthly premium of 100% of the total plan costs.

When coverage ends

Coverage ends if:

- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may continue under the new plan
- You and your dependents fail to make the necessary premium payments on time
- You or a covered dependent become entitled to benefits under Medicare
- You or a covered dependent become covered under another plan

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

How you can extend coverage for your child beyond the plan age limits

You have the right to extend coverage for your child beyond the plan age limits if your child meets all the following requirements:

- Your child is an Ohio resident or, if not a resident of Ohio, the child is a full-time student at an accredited public or private institution of higher education
- Your child is eligible for coverage through their employer who offers any health plan
- Your child meets all other eligibility requirements
- Your child or you requests continuation of coverage within 31 days of your child's attainment of the plan age limit, or during an open enrollment
- Your child or you agree to pay the full cost of the child's coverage]

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Ohio Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

Maximum coinsurance differential for network plans

In no event will the covered amount for In-Network charges exceed more than 30% of the covered amount for Out-of-Network charges.

Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Mammograms

Mammography screening is not subject to **deductible, copayment, or coinsurance**, if any applies under the plan.

Prescription Drugs

Up to a 90 day supply of prescription drugs may be obtained from a retail or mail order drug pharmacy.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will acknowledge written complaints within five (5) working days after receipt. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

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

Claim decisions and appeal procedures

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

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

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

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

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

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

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

Exhaustion of appeal process

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

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

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

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

External review

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

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

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

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

You must submit the request for external review form:

- To the Oklahoma Insurance Commissioner
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Oklahoma Insurance Commissioner will select an approved ERO that will conduct the review of your claim. The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits

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

How long will it take to get an ERO decision?

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

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

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

For initial adverse benefit determinations

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

For final adverse determinations

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

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

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

Utilization review

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

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

Recordkeeping

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

Fees and expenses

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

Recovery of overpayments

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

We will request the return of overpayment within 24 months after the payment is made, except in cases:

- Of fraud
- When you or your provider has already agreed to refund us for the overpayment

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: Oklahoma Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate.

Precertification

In accordance with state law timeframes, we will tell you and your **physician** in writing of the **precertification** decision or if we need additional information. An approval is valid for 180 days as long as you remain enrolled in the plan.

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Hearing aids and hearing assistive technology systems

Hearing aid means:

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

Hearing assistive technology means:

- Devices used to improve your ability with hearing loss in situations such as:
 - Being located a distance from a speaker,
 - In an environment with competing background noise
 - In a room with poor acoustics or reverberation.

Covered services include prescribed hearing aids, hearing assistive technology systems and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
 - A **physician** certified as an otolaryngologist or otologist
 - An audiologist who:
 - is legally qualified in audiology
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements

- Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Bone conduction sound processors
- Any other related services necessary to access, select, and adjust or fit a hearing aid

A hearing aid maximum of one per ear every 36 months applies.

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

The following has been added to or replaced in the *Eligibility, Starting and Stopping Coverage* section of your booklet-certificate.

Domestic Partners

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

- Your domestic partner and their dependent children who meet the rules set by the **policyholder** and requirements under Oregon state law

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Oregon Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Nutritional support

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

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids. No deductible applies unless this benefit is provided under a qualified High Deductible Plan.

The following are not **covered services**:

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

The following has been added to or replaced in the *Coverage and exclusions, Prescription drugs – outpatient* section of your booklet-certificate.

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

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

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

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

Amendment: Pennsylvania Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Cleft lip and palate

Covered services include treatment of cleft lip and palate and any related condition or **illness**. These services are covered based on type of service and where it is received. This includes but not limited to:

- Oral and facial **surgery**, surgical management and follow up care
- Prosthetic treatment such as obturators and speech and feeding appliances
- Orthodontic and prosthodontic treatment and management
- Otolaryngology treatment and management
- Audiological assessment, treatment and management include surgically implanted amplification devices
- Physical therapy

The following has been added to or replaced in the **Hospital** care subsection within the *Coverage and exclusions* section of your booklet-certificate.

For mastectomy, 48 hour of inpatient care in a network hospital. In case of early discharge, one home visit if ordered by your attending physician.

The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

Continuation of coverage under South Carolina law

You may continue coverage for the remaining of the month in which your coverage ended plus an additional 6 months if:

- You have been continuously covered under this plan for at least 6 months before it was ended
- The plan was ended due to any reason other than nonpayment of the premium, and
- You are not eligible for:
 - Other group coverage that provides similar benefits
 - Medicare benefits
 - COBRA

Upon termination, the contract holder will notify you of your right to continue coverage and the amount of your premium. You need to send the application within 30 days after the qualifying event.

Continuation of coverage ends if:

- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may be continued under the new plan
- You fail to make the necessary payments on time
- You become covered under another group health plan that provides similar benefits
- You become entitled to benefits under Medicare

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



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

Amendment: South Carolina Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles, and pens
 - Test strips - blood glucose, ketone, and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

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



Dan Finke

President

Aetna Life Insurance Company

(A Stock Company)

Amendment: South Dakota Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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 trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

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

Participation in a clinical trial will not be the sole reason to deny coverage.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake up to 18 months after the overpayment was received, except in cases of fraud.

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



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

Amendment: Tennessee Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

The following has been added to or replaced in the *Preface* section of your booklet-certificate.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277

Toll-free: 1-888-416-2277

Online: www.aetna.com

Email: aetnamemberservices@aetna.com

Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277

Teléfono gratuito: 1-888-416-2277

En línea: www.aetna.com

Correo electrónico: aetnamemberservices@aetna.com

Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Preferred Provider Disclosure Notice

- You have the right to an adequate network of preferred **providers** (also known as "network providers").
 - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
 - If you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network **deductible** and out-of-pocket maximum.
- You have the right, in most cases, to obtain estimates in advance:
 - from **out-of-network providers** of what they will charge for their services; and
 - from your insurer of what it will pay for the services.
- You may obtain a current **directory** of preferred **providers** at the following website: www.aetna.com or by calling **Aetna** Member Services at the toll-free number on your ID card for assistance in finding available preferred **providers**. If the **directory** is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
- If you are treated by a **provider** or **hospital** that is not a preferred **provider**, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network **hospital**-based radiologist, anesthesiologist, pathologist, emergency department **physician**, neonatologist, assistant surgeon, out-of-network emergency care **provider** or any out-of-network **provider** working at a network facility is greater than \$500 (not including your **copayment**, **coinsurance**, and **deductible** responsibilities) for services received in a network **hospital**, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

The insurance policy under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Underwritten by Aetna Life Insurance Company

The following content is added or replaced in the *Coverage and Exclusions* section of your booklet-certificate:

Autism spectrum disorder

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

Covered services include the “generally recognized services provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan. You can receive treatment from a **provider** that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States.
- Is certified as a **provider** under the TRICARE military health system.

You can also receive treatment from someone working under the supervision of a **provider** as described above. As used here, “generally recognized services” can include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Physical therapy
- Occupational therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Behavioral health

Mental health treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, crisis stabilization unit, residential treatment center for children and adolescents, or residential treatment facility.**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** or **telehealth** consultation)
 - Individual, group, and family therapies for the treatment of **mental health disorders**
 - Other outpatient mental health treatment such as:
 - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**

- Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - 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
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Substance related disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** or **telehealth** consultation)
 - Individual, group, and family therapies for the treatment of **substance related disorders**
 - Other outpatient **substance related disorders** treatment such as:
 - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
 - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
 - Observation
 - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Cardiovascular disease testing

Covered services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

- Diabetes
- An intermediate or higher risk of getting coronary heart disease based on Framingham Heart Study prediction algorithms

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

- Computed tomography (CT) scanning
- Ultrasonography

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial as a qualified individual for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
 - The study or investigation is approved or funded by one or more of the following:
 - The National Institutes of Health
 - The Centers for Disease Control and Prevention
 - The Agency for Health Care Research and Quality
 - The Centers for Medicare & Medicaid Services
 - Cooperative group or center of any of the entities described above or the Department of Defense or the Department Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - The Department of Veterans Affairs
 - The Department of Defense
 - The Department of Energy
 - The Food and Drug Administration
 - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

The following are not **covered services**:

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- Your **provider** determines, and we agree, that based on published, peer-reviewed scientific evidence you may benefit from the treatment

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

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

Dental care services and anesthesia in a hospital or surgery center

Covered services include anesthesia and facility costs for dental care. Your provider must certify that the dental care cannot be performed in the dentist’s office due to a physical, mental, or medical condition.

The following are not **covered services**:

- The related dental services unless specifically listed as a covered service in this certificate.

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

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Insulin and insulin analog preparation
 - Prescribed oral medications whose primary purpose is to influence blood sugar
 - Injection devices including syringes, needles and pens
 - Injection aids, including devices used to assist with insulin injection and needleless systems
 - Diabetic test agents, including but not limited to, visual reading and test strips (blood glucose, ketone and urine)
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
 - Injectible glucagon's
 - Glucagon emergency kit
 - Biohazard disposal containers
- Equipment
 - External and implantable insulin pumps and pump supplies
 - Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement
 - Rental fees for pumps during repair and maintenance
 - Blood glucose monitors without special features, unless required due to blindness
 - Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Covered services also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- **Prescribed** by your **provider**
- Sent to us in writing by your **provider**

All supplies, including medications and equipment for diabetes will be dispensed as written, and are not subject to preauthorization or step therapy requirements.

Diagnostic follow-up care related to newborn hearing screening

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

Important Note:

Once you have met your **deductible**, your cost share for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging will be the same as mammograms performed for routine cancer screenings as described in the *Preventive Care* section when it is used to evaluate a breast abnormality detected by a **physician** or patient, or where there is a personal history of breast cancer or dense breast tissue.

This diagnostic imaging is not subject to any age limitations

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network providers** or **out-of-network providers**.

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists.
- Treatment to stabilize your condition.
- Care in an emergency facility, freestanding emergency care facility or comparable facility after you become stable. But only if the treating **provider** asks us, and we approve the service. We will approve or deny the request within an hour after receiving the request.

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**. When you are treated by an **out-of-network provider** when a **network provider** is not reasonably available or for an **emergency medical condition**, we will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact us if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

You will be credited for:

- Any amounts due to you that would have been paid if the **provider** were a **network provider**
- Any out-of-pocket amounts that you paid to the **provider**, in excess of the allowed amount. Such amounts will be credited to your Calendar Year **deductible** amount and plan **coinsurance** limits, as applicable

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan based on the usual and customary rate or at an agreed rate. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and preauthorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician (PCP)**.

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for this information.

Hearing aids, cochlear implants and related services

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

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

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

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

The following are not **covered services**:

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

Home health care

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

- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**
- The services are a part of a home health care plan
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

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

The following are not **covered services**:

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

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including care and services for complications of pregnancy.

Complications of pregnancy are:

- Conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:
 - Acute nephritis
 - Nephrosis
 - Cardiac decompensation
 - Missed abortion
 - Similar medical and surgical conditions of comparable severity
- The following conditions that occur during a period of gestation in which a viable birth is not possible:
 - Non-elective cesarean section
 - Termination of ectopic pregnancy
 - Spontaneous termination of pregnancy

Complications of pregnancy do not include:

- False labor
- Occasional spotting
- Physician prescribed rest during the period of pregnancy
- Morning sickness
- Hyperemesis gravidarum
- Pre-eclampsia
- Similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Services and supplies for complications of pregnancy will be covered the same as any other illness or injury.

After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **health care facility** after a vaginal delivery
- No less than 96 hours of inpatient care in a **health care facility** after a cesarean delivery
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 after delivery by a health care **provider**.

These time frames apply if your child is born without any problem. If your **provider** tells us that you had a problem during your pregnancy or during childbirth, we will cover the **stay** the same as we would for any other illness or injury.

Covered services for newborn care include:

- Services and supplies needed for circumcision by a **provider**
- Treatment of congenital defects. These services will be covered the same as any other illness or injury

The following are not **covered services**:

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

Nutritional support

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

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid based elemental formula.

We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

The following are not **covered services**:

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

Orthotic devices

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

We will cover the same type devices that are covered by Medicare. Your **provider** will tell us which device best fits your need. But we cover it only if we **preauthorize** the device.

Orthotic device means a customized medical device applied to a part of the body to:

- Correct a deformity
- Improve function
- Relieve symptoms of a disease

Coverage Includes:

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

The following are not **covered services**:

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Osteoporosis

Covered services include services to detect and prevent osteoporosis for:

- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with:
 - Vertebral abnormalities
 - Primary hyperparathyroidism
 - A history of bone fractures
- An individual who is:
 - Receiving long-term glucocorticoid therapy
 - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** or **telehealth**

Important note:

For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** or **telehealth** instead.

Other services and supplies that your **physician** may provide:

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

The Types of services that require preauthorization section is revised as follows:

A **preauthorization** may not be required for some services if your **provider** meets the requirements of prior **preauthorization** approvals. Please contact your **physician** or us for additional information.

Your **provider** may request a renewal of an existing **preauthorization** within 60 days of the expiration date of the preauthorization. We will notify you of our decision before the expiration of the existing **preauthorization**.

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that:
 - The quantity requested is to synchronize the dates that the **pharmacy** fills your **prescription drugs**
 - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

Prescription eye drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
 - 21st day after the date a 30-day supply is dispensed
 - 42nd day after the date a 60-day supply is dispensed
 - 63rd day after the date a 90-day supply is dispensed

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost sharing for anti-cancer **prescription drugs** will not exceed the coinsurance or copayment applicable to a chemotherapy visit or cancer treatment visit. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. For more information see the *How your plan works – Medical necessity and preauthorization requirements* section.

Nutritional supplements

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino-acid based elemental formula.

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

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

The following has been added to or replaced in the *Preventive care* section of your certificate

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, or a follow-up colonoscopy if the findings are abnormal
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

The following has been added to or replaced in the *Preventive care* section of your schedule of benefits

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no deductible applies	50% per visit after deductible No deductible, copayment or coinsurance applies to immunizations for children through age 6
Breast feeding counseling and support	100% per visit, no deductible applies	50% per visit after deductible
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no deductible applies	50% per visit after deductible
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no deductible applies	50% per visit after deductible
Counseling for obesity, healthy diet	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no deductible applies	50% per visit after deductible
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no deductible applies	50% per visit after deductible
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (contraception counseling)	100% per visit, no deductible applies	50% per visit after deductible
Family planning services (contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no deductible applies	50% after deductible No deductible, copayment or coinsurance applies to immunizations for children through age 6
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Routine cancer screenings	100% per visit, no deductible applies	50% per visit after deductible
Mammogram limits	One mammogram every year for covered persons 35 and older. When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.	One mammogram every year for covered persons 35 and older. When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.
Prostate specific antigen (PSA) test limits	One PSA test every year for covered persons age 45 and over One PSA test every year for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	One PSA test every year for covered persons age 45 and over One PSA test every year for covered persons age 40 and older with a family history of prostate cancer, or other risk factor
Additional routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section

Routine lung cancer screening	100% per visit, no deductible applies	50% per visit after deductible
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no deductible applies	50% per visit after deductible
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no deductible applies	50% per visit after deductible
Pap smear or screening using liquid based cytology methods	One pap smear every 12 months for women age 18 or older	One pap smear every 12 months for women age 18 or older
Gynecological exam that includes a rectovaginal pelvic exam	One exam every 12 months for women over age 25 who are at risk for ovarian cancer	One exam every 12 months for women over age 25 who are at risk for ovarian cancer
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	One exam every 12 months for women age 18 and older	One exam every 12 months for women age 18 and older
Additional well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit	1 visit

Prosthetic device

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

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
 - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
 - Treatment of physical complications of all stages of the mastectomy, including lymphedema
 - Protheses
- Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
 - 96 hours of inpatient care following a mastectomy
 - 48 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
 - The defect results in severe facial disfigurement or major functional impairment of a body part
 - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if:
 - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Inpatient and outpatient treatment for acquired brain injury

Covered services include treatment for an acquired brain injury. An acquired brain injury does not include a congenital or degenerative illness or injury. It means a neurological injury to the brain, after birth, that results in loss of:

- Physical function
- Sensory processing
- Cognition
- Psychological behavior

The therapy is coordinated with us as part of a treatment plan intended to:

- Maintain or restore previous cognitive function
- Slow further loss of function

Covered services include the following therapies related to an acquired brain injury:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment.
- Neurofeedback therapy
- Remediation
- Post-acute transition services
- Community reintegration services
- Post-acute care treatment due to, and related to, an acquired brain injury. If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive.

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

- Within scope of their license, and
- Within scope of the services provided under an accredited rehabilitation program for brain injury.

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

The following content is added or replaced in the *Coverage and Exclusions* and *Glossary* section of your certificate:

Telemedicine, teledentistry or telehealth

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

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

The following are not **covered services**:

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

Teledentistry

A health care service delivered by a dentist, or a **health professional** acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or **health professional's** license or certification to a patient at a different physical location than the dentist or **health professional** using telecommunications or information technology.

Therapies – chemotherapy

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Covered services also include anti-cancer **prescription drugs** for chemotherapy. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medication covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost-sharing for anti-cancer prescription drugs will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

The following content is added or replaced in the *How your plan pays* section of your booklet-certificate:

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

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

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

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

	If you are a new enrollee and your provider is out of network provider	When your provider stops participation with Aetna
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your provider should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period for up to 90 days. This date is based on the date the provider terminated their participation with us.
How claim is paid	Your claim will be paid at the designated network cost sharing level during the transitional period.	Your claim will be paid at the designated network cost sharing level during the transitional period.

	If you have a terminal illness and your provider stops participation with us
Request for approval	Your provider should call us for approval to continue any care. You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 9 months. This date is based on the date the provider terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

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

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

Coordination of benefits

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

Order of benefit determination rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

<ul style="list-style-type: none">• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan
<ul style="list-style-type: none">• A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:<ul style="list-style-type: none">- Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are:<ul style="list-style-type: none">○ Major medical coverages that are superimposed over base plan hospital and surgical benefits○ Insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.
<ul style="list-style-type: none">• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
<ul style="list-style-type: none">• If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an out-of-network provider or physician except for emergency services or authorized referrals that are paid or provided by the primary plan.
<ul style="list-style-type: none">• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with these rules.
<ul style="list-style-type: none">• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.

Key Terms

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

Plan:

A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

<ul style="list-style-type: none"> • A plan includes: 	<ul style="list-style-type: none"> • Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage • Individual and group health maintenance organization evidences of coverage • Individual accident and health insurance policies • Individual and group preferred provider benefit plans and exclusive provider benefit plans • Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care • Medical care components of individual and group long-term care contracts • Limited benefit coverage that is not issued to supplement individual or group in-force policies • Uninsured arrangements of group or group-type coverage • The medical benefits coverage in automobile insurance contracts • Medicare or other governmental benefits as permitted by law
<ul style="list-style-type: none"> • A plan does not include: 	<ul style="list-style-type: none"> • Disability income protection coverage • The Texas Health Insurance Pool • Workers' compensation insurance coverage • Hospital confinement indemnity coverage or other fixed indemnity coverage • Specified disease coverage • Supplemental benefit coverage • Specified accident coverage • School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis • Benefits provided in Long-term care insurance contracts for non-medical

	<p>services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services</p> <ul style="list-style-type: none"> • Medicare supplement policies • A state plan under Medicaid • A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan • Other nongovernmental plan • An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible
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Each plan for coverage is a separate plan, If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan

This plan:

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans

<ul style="list-style-type: none"> • How this plan coordinates with like benefits: 	<p>Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.</p>
<ul style="list-style-type: none"> • The order of benefit determination rules for this plan: 	<p>The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.</p> <ul style="list-style-type: none"> • When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan’s benefits • When this plan is secondary, it determines its benefits after those of another plan an may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense

Allowable expense:

Allowable expense is a health or dental care expense, including **deductibles**, coinsurance and **copayments**, that is covered at least in part by any plan covering the person.

<ul style="list-style-type: none">• Allowable expense for benefits provided in the form of services:	When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
<ul style="list-style-type: none">• Expenses that are not allowable expenses:	<p>An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.</p> <p>Some expenses and services are not allowable expenses. Here are some examples:</p> <ul style="list-style-type: none">• The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.• If a person is covered by two or more plans that don't have a negotiated charge and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for specific benefit is not an allowable expense.• If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.• If a person is covered by one plan that does not have negotiated charges and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on negotiated charges, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care

	<p>provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated charge or payment amount that is different than the primary plan's payment arrangement and if the health care provider or physician contract permits, the negotiated charge or payment must be the allowable expense used by the secondary plan to determine its benefits.</p> <ul style="list-style-type: none"> • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and network provider and physician arrangements.
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Allowed amount:

Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an **out-of-network provider**. The amount includes both the carrier's payment and any applicable **deductible, copayment,** or coinsurance amounts for which the insured is responsible.

Closed panel plan:

Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care **providers** and **physicians** that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care **providers** and **physicians**, except in cases of emergency or referral by a panel member.

Custodial parent:

Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	<p>Plan covering you as an employee, policyholder, retired employee or subscriber (not as a dependent)</p> <p>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</p>	<p>Plan covering you as a dependent</p> <p>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</p>
Child – parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together, whether or not they have ever been married	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent’s plan if there is no court order 	<ul style="list-style-type: none"> • Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent’s plan
Child – covered by individuals who are not his or her parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Child of: Persons who are not his or her parents	The rules shown for parents will apply, as if the persons were parents of the child	The rules shown for parents will apply, as if the persons were parents of the child

Child of: Parents, who is also covered under a spouses plan	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.
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Active or inactive employee This rule does not apply if: <ul style="list-style-type: none"> • The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits • The “Non-dependent or Dependent” paragraph, above can determine the order of benefits 	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
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Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation This rule does not apply if: <ul style="list-style-type: none"> • The other plan does not have the rule, and as a result, the plans do not agree on the order of benefits • The “Non-dependent or Dependent” paragraph, above can determine the order of benefits 	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
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Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
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Other rules do not apply	Plans share expenses equally This plan will not pay more than it would have paid had it been the primary plan.	Plans share expenses equally This plan will not pay more than it would have paid had it been the primary plan.
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Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
 - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
 - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
 - Must credit to its plan **deductible** any amounts it would have credited to its **deductible** in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel **provider**, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from 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 the benefits provided in the form of services.

Other health coverage updates – contact information

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

Recovery rights related to workers' compensation

If we pay more than we should have because workers' compensation benefits paid for the same illness or injury we may recover the excess from any of the following:

- Any person we paid or for whom we paid
- Any workers' compensation plan that is responsible for payment
- Any fund designed to provide benefits for workers' compensation claims

The recovery rights will be applied even if:

- The benefits are in dispute or are paid by means of settlement or compromise
- No decision has been made that the illness or injury was in the course of, or due to, your employment
- No agreement has been made by you, or the workers' compensation plan, about the amount of benefits due to health care
- The health care benefits are excluded from the workers' compensation settlement or compromise

By accepting benefits under this plan, you or your representatives agree to:

- Notify us of any workers' compensation claim made
- Reimburse us as described

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

The following content is added or replaced in the *Complaints, claim decisions and appeal procedures* section of your booklet-certificate:

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You, someone who represents you, or your provider may file the complaint. You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determination* sections for more information

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Adverse determinations

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

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

If we deny health care services because your **provider** does not request **preauthorization** or a concurrent claim extension, it is not an adverse determination.

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

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
 - A life threatening condition

- The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the policy
- Requests for **step therapy** exception

The chart below shows how much time we have to tell you about an adverse determination.

Type of notice	When you need care to make sure you are stable following emergency treatment (post-stabilization)	While you are in the hospital	When not hospitalized at the time of the decision	Prescription drugs or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating provider	Within 1 business day by phone or email to your provider followed by written notice within 3 business days to you and your provider	Within 3 business days to you and your provider	No later than 30 th day before on which the prescription drugs or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (us)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response to additional information request (you)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

Important note:

We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell no later than the times shown in the chart above.

Appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complaint* and *Appeal of adverse determinations* sections below explain the appeal.

Claim decisions and appeal procedures

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

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

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider in the review your appeal. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee members.
- Texas Health Aetna representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in making the decision. We will use a **provider** with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the **physician** or **providers** consulted during the review
- The name and affiliation of all Texas Health Aetna representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel’s understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

Appeal of an adverse determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

You can appeal by sending a written appeal to the address on the notice of adverse determination, or by contacting us. You need to include:

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

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

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

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

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

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

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.

Important note:

You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determination

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

Type of claim	Our response time from receipt of appeal
Urgent care claim	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
Emergency medical condition	As soon as possible but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than 1 hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of hospital stays)	No later than 1 business day from the date all information to complete the review is received*
If you are receiving prescription drugs or intravenous infusions	As soon as possible but no later than 1 business day from the date all information to complete the review is received*
Pre-service claim requiring preauthorization	As soon as possible but no later than 15 calendar days*
Requests for step-therapy exception (non-emergency)	No later than 72 hours after we receive the request
Requests for step-therapy exception (emergency)	No later than 24 hours after we receive the request
Acquired brain injury	No later than 3 business after the request
Retrospective claim	As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must be made no later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeal process

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

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

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

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the independent review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the Texas and the federal Department of Health and Human Services. But you will not be able to proceed directly to independent review if:
 - The rule violation was minor and not likely to influence a decision or harm you
 - The violation was for a good cause or beyond our control
 - The violation was part of an ongoing, good faith exchange between you and us
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

Independent review

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

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

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

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

You must submit the request for independent review form:

- To Texas Health Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

Texas Health Aetna will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO will:

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

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

How long will it take to get an IRO decision?

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

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

You may be able to get a faster independent review after an adverse determination if:

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

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hour if your request is for an exigent circumstance.

Utilization review

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

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

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

The following content is added or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate:

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including any children placed with you for adoption*
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody
 - Grandchild who is your dependent for federal tax purposes at the time application for coverage of the grandchild is made
 - A grandchild whose parent is already covered as a dependent on this plan

*Your adopted child may be enrolled as shown in the *When you can join the plan* section, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth:
 - Your newborn child is covered on your health plan for the first 31 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- Adoption or placement for adoption:
 - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after you become a party in a suit for adoption or the adoption is complete.
 - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become a party in a suit for adoption or the adoption is complete.
 - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required premium contributions, if any apply
- We end your coverage for one of the reasons shown in this section
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
 - Exhaustion of your overall maximum benefit.
 - You enroll under a group Medicare plan we offer.

Your employer will notify Aetna of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

- Your employer notifies you at least 30 days before coverage ends
- You and your dependents are covered under COBRA or state continuation
- You and your dependents are enrolled in another health plan that starts before the end of the month after we receive the notice

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

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

We will not end your coverage based on your health care status or needs, we also will not end your coverage because you used your rights under the *Complaints, claim decisions, and appeal procedures* section.

Continuation of coverage – State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

Qualifying event causing loss of coverage:	Covered persons eligible for continued coverage:	Length of continued coverage (starts from the day you lose current coverage):
<ul style="list-style-type: none"> • Death of employee • Retirement of employee • Retirement of employee 	<ul style="list-style-type: none"> • Dependent who has been covered under the plan for at least one year • An infant under one year of age 	3 years

When do I receive state continuation information?

The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

Notice	Requirement	Deadline
You or your covered spouse	Send written notice to your employer	Within 15 days of the qualifying event
Your employer	Will provide you with an enrollment form to continue coverage	No later than 15 days after they receive notification
You or your covered spouse	Complete the enrollment form to continue coverage	Within 60 days of the qualifying event.

You must send the completed enrollment form from within 60 day of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

Group continuation privilege

You may continue coverage if your coverage ends for any reason except:

- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:

- Your coverage ends or
- You are given notice by the contract holder

Your first **premium** payment must be made within 45 days after the date of the coverage election. After that, **premium** payments are due no later than the end of the grace period after the **premium** due date.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA
- The date you fail to pay premiums
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

Continuation of coverage for other reasons

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

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

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

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

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

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

The following content is added or replaced in the *General Provisions* section of your booklet-certificate:

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan

We apply policies and procedures we’ve developed to administer this plan.

Who’s responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **preauthorization, prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this. Any modifications made will be no less favorable than the current plan requirements.

Legal action

You are encouraged to complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions, and, appeal procedures* section. You cannot take any action until 60 days after we receive written submission of a claim.

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

Notice of claim

You must give us written notice of claim within 20 days (or as soon as reasonably possible) after you have incurred expenses for **covered services**. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Physical examination and evaluations

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

Proof of loss

You must submit written proof of loss you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years after the effective date of this certificate.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by an independent IRO

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

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made by the end of the grace period. Any decision to not pay benefits can be appealed.

When you are injured by a third party

If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, we are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right, you are:

- Agreeing to repay us from money you receive from those third parties because of your injury.
- Giving us the right to seek money in your name, from those third parties because of your injuries.
- Agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to our portion of the money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:

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

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

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

How will Attorney's fees be determined?

If we do not use an attorney:

- We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses
- If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery

If we use an attorney:

- The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors) recovery.

Payor means a plan issuer that:

- Has a contractual right of subrogation, and
- Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct

A payor includes, but is not limited to, an issuer of:

- A health benefit that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan

Payment to a conservator, other than you

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on a unpaid medical bill
- You sent us a claim for benefits for covered services that you paid

Reimbursement to Texas Department of Human Services

We will repay the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
 - Have possession or access to the child through a court order; or
 - Are not entitled to possession of our access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Department of Human Services.

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

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



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

Amendment: Texas Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

Adoption benefit

Covered services include an adoption benefit up to \$4,000 and apply the same **copays, deductibles, and coinsurance** as any other maternity service.

Coverage is limited to the following requirements:

- The adopted child has been placed with you within 90 days from birth.
- The adopting parent(s) must submit copies of the placement papers to us.

We may seek reimbursement for the adoption benefit if:

- The post placement evaluation disapproves the adoption.
- A court rules the adoption may not be finalized.

Important note:

If both adopting parents have maternity coverage provided by different insurers, we will coordinate payment with the other plan and the total benefit will not exceed \$4,000. If more than one child from the same birth is adopted, only one benefit is applied.

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis.

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

- Systematically change behavior
- Are responsible for observable improvements in behavior

Important note:

Applied behavior analysis may require **precertification** by us. See the *How your plan works – Medical necessity and precertification* section.

The following has been added to or replaced in the *General plan exclusions* section of your booklet-certificate.

Abortion

Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger, or if the fetus has a defect that is documented by a physician or physicians to be uniformly diagnosable and ultimately lethal.

Behavioral health treatment

Services for the following based on categories, conditions, diagnoses, or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association:

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Education service, including special education service, remedial education service, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section
- Pathological gambling, kleptomania, and pyromania

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program.

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



Dan Finke

President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Utah Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company



NOTICE OF PROTECTION PROVIDED BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
 - \$500,000 in death benefits
 - \$200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
 - \$500,000 for health benefit plans
 - \$500,000 in disability income insurance benefits
 - \$500,000 in long-term care insurance benefits
 - \$500,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at <https://www.ulhiga.org/>, or contact:

Utah Life and Health Insurance Guaranty Assoc.
466 South 500 East, Suite 100
Salt Lake City, UT 84102
(801) 320-9955

Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129
(801) 957-9200

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

Medical exceptions – prescription drugs

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. After we receive your request and any information, we will:

- Review and act upon your request within one business day
- Tell you and your **prescriber** of our coverage determination within 72 hours

Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

If your plan uses a **preferred drug guide**, we will approve a medical exception for a **non-preferred drug** after reviewing and discussing with your prescriber if:

- We determine that the **preferred drug** is not appropriate therapy for your medical condition
- You have been receiving the **non-preferred drug** for at least six months before the development or revision of the **preferred drug guide** and your **prescriber** determines one of the following:
 - The **preferred drug** is not appropriate therapy for your medical condition
 - Changing drug therapy presents a significant health risk to you

You or your **prescriber** may seek an expedited medical exception for non-covered or **non-preferred drugs** in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-covered or **non-preferred drug**. You or your **prescriber** may submit a request for an expedited review for an urgent situation by:

Contacting our Precertification Department at 1-855-582-2025

Faxing the request to 1-855-330-1716

Submitting the request in writing to CVS Health ATTN: **Aetna** PA 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you and your **prescriber** of our decision.

If you are denied a medical exception based on the above processes, you may have the right to a third-party review by an independent review organization (IRO). If our coverage determination is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you and your **prescriber** of the coverage determination of the external review no later than 72 hours after we receive your request. For expedited medical exceptions in urgent situations, we will tell you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request.

If the medical exception is approved by us, or by the IRO:

- The exception will apply for the entire time of the **prescription**, or in the case of an expedited exception, for the entire time you have an urgent situation
- The cost share will be applied the same as for a **drug** listed in the **preferred drug guide**

Partial fill dispensing to synchronize prescription drugs and specialty prescription drugs

We allow a partial fill of your **prescription** to synchronize the dates that the **pharmacy** fills your **prescription drugs**, including **specialty prescription drugs**, provided that:

- The **prescription** is dispensed by a **network pharmacy**
- Your **pharmacy** or **prescriber** tells us that the synchronization of the dates is in your best interest
- You request or agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply. We will not perform this proration more often than annually.

Insulin Important note

Your cost share will not exceed \$50 per 30-day supply of a covered **prescription** insulin drug filled at a **network pharmacy**.

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



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

Amendment: Virginia Medical ET
Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

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

Domestic Partners

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

- Your domestic partner and their dependent children

Adding new dependents

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

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

Mammograms

Eligible health services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis)

Neurodevelopmental therapy

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

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

Home health care

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

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

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

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

Exclusions

Your plan does not cover the following under this section:

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

Hospice care

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

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

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

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

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

Exclusions

Your plan does not cover the following under this section:

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

Abortion

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

Acupuncture

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

Nutritional supplements

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

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

Exclusions

Your plan does not cover the following under this section:

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

Jaw joint disorder treatment

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

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

The following are not covered under this benefit:

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

Physician

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

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

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

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

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

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

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

Coordination of benefits

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

Key terms

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

Allowable expense means:

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

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

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

Here’s how COB works

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

Determining who pays

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

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as a non-dependent	The plan covering you as a dependent
Exception to the rule above when you are eligible for Medicare	<p>If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us:</p> <ul style="list-style-type: none"> • Online: Log on to your Aetna secure member website at www.aetna.com • By phone: Call the number on your ID card 	
COB rules for dependent children		
Child of: <ul style="list-style-type: none"> • Parents who are married or living together 	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year . *Same birthdays-the plan that has covered a parent longer is primary.	The plan of the parent born later in the year (month and day only).* *Same birthdays-the plan that has covered a parent longer is primary.
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together • With court-order 	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then their spouse’s plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse’s plan is primary.
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody 	Primary and secondary coverage is based on the birthday rule.	
Child of: <ul style="list-style-type: none"> • Parents separated or divorced or not living together and there is no court-order 	The order of benefit payments is: <ul style="list-style-type: none"> • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last 	
Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See <i>Child of</i> content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active	A plan that covers the person as a laid off or retired employee (or as a dependent of a former

	employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

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

How COB works with Medicare

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

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

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

- Age
- Disability
- End stage renal disease

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

Who pays first?

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

This plan is secondary to Medicare in all other circumstances.

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

Other health coverage updates – contact information

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

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

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

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

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

Types of claims and communicating our claim decisions

You or your **provider** is required to send us a claim in writing. If you or your dependent goes to a **network provider**, the **network provider** will file the claims. When you go to an **out-of-network provider**, you will have to file the claims. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

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

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	Within 48 hours or Within 1 business day for an emergency request	5 calendar days	30 calendar days	No later than 24 hours for urgent request* or 5 calendar days for non-urgent request
Request for Extension	Not applicable	Within 5 calendar days	15 calendar days	Not applicable
Additional information request (us)	24 hours	5 calendar days	30 calendar days	Not applicable
Response to receipt of additional information request (you)	48 hours	30 calendar days	45 calendar days	Not applicable

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

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** if you go to a **network provider** and the **recognized charge** if you go to an **out-of-network provider**, except for your share of the costs.

But sometimes we may pay only some of the claim. And sometimes we may deny payment or service entirely.

We may sometimes:

- Deny
- Change
- Reduce, or
- Terminate your
- Health care services or benefits
- Authorization relating to such services or benefits, or
- Coverage or payment for the health care services or benefits

Such actions are called “adverse benefit determinations.” Other actions that are also called “adverse benefit determinations” include:

- We do not authorize a **stay** in a **hospital** or other facility
- We decide that you or your dependents were not eligible for the coverage when you received the services
- We decide that you have reached your benefit maximums
- Your health care services are excluded, not covered or limited in some way
- We rescind your coverage entirely

Reasons for adverse benefit determinations may be:

- The results of utilization review activities
- The health care services are **experimental or investigational**
- The health care services are not **medically necessary**

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

The difference between a grievance and an appeal

A grievance

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

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	24 hours, but no longer than 72 hours	14 days, or 20 days for an experimental or investigational treatment. We will let you know within 72 hours that we have received your appeal		As appropriate to type of claim
Extension to respond (us)	None	16 additional days, if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.		

Exhaustion of appeals process

In most situations you must complete the one level of appeal with us before you can pursue arbitration, litigation or other type of administrative proceeding.

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

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally. See the *How to contact us for help* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of Washington or of the Federal Department of Health and Human Services. You will not be able to proceed directly to external review if the violation was:
 - Minor and not likely to influence a decision or harm you
 - For a good cause or beyond our control
 - Part of an ongoing, good faith exchange between you and us

At any time you may contact the Washington Office of the Insurance Commissioner to request an investigation of a grievance or appeal.

External review

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

You have a right to external review if:

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

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 180 calendar days of the date you received the decision from us

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

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

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Will accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

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

For initial adverse determinations

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

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

For final adverse determinations

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

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

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

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a grievance or appeal.

Out-of-network benefits disclosure

Your health plan's out-of-network benefits

Not all health coverage plans provide out-of-network benefits. Please refer to your schedule of benefits for a description of your health plan's out-of-network benefits.

Notice of consumer rights

Washington State has developed a notice of consumer rights. You can find this in your certificate of coverage.

Out-of-network costs

You may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on whether the provider, a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

"In network" means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance, copayments, and deductible that applies. Your network doctor will handle any precertification your plan requires.

"Out of network" means we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna® health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that the plan doesn't recognize. You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

How to use the transparency tool

Aetna provides online tools to help you determine the cost of health care services and your potential share of those expenses. After logging in to our member website, you can search for procedures and providers to see estimated costs.

Search our network for doctors, hospitals and other health care providers

Use our online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by ZIP code or enter a specific doctor's name in the search field.

Visit **Aetna.com** and log in. From your secure member website home page, select "Find Care" from the menu bar and start your search.

Our online search tool is more than just a list of doctors' names and addresses. It also includes information about:

- Where the doctor went to medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Obtain an estimated range of the out-of-pocket costs for an out-of-network benefit

Contact member services at the number on your ID card for help estimating your out-of-pocket cost for an out-of-network benefit. Out-of-network providers do not have a contracted rate with Aetna. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. However, your out-of-pocket costs may be much higher compared to the costs of using a network provider. Your out-of-pocket costs for an out-of-network benefit, if included in your plan, consists of your out-of-network deductible plus your plan coinsurance. To estimate your coinsurance amount, subtract the remaining plan deductible from the provider's billed charge. Then multiply the balance by your coinsurance percentage.

Policies and plans are insured and/or administered by Aetna Life Insurance Company or its affiliates (Aetna).

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to **Aetna.com** for more information about Aetna® plans.

Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted, or if the doctor or facility performs a different service at the time of your visit

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



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

Amendment: Washington Medical ET

Issue Date: January 16, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-0805902

Amendment effective date: January 1, 2023

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate:

Mail order pharmacy

You are not required to obtain any prescription drug refill from a network mail order pharmacy or CVS pharmacy.

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



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

Amendment: West Virginia Medical ET
Issue Date: January 16, 2023