SECTION XXV

EXCLUSIVE PROVIDER ORGANIZATION SCHEDULE OF BENEFITS
Aspen HR PEO, LLC

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual • Family	 $1,000 per Plan Year $2,000 per Plan Year	
Prescription Drug Deductible • Individual • Family	 $100 per Plan Year $300 per Plan Year	
Out-of-Pocket Limit • Individual • Family	 $5,500 per Plan Year $11,000 per Plan Year	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$20 plus 0% per visit thereafter, no Deductible applies in Office by Telehealth	See benefit for description
Specialist Office Visits (or Home Visits)	$65 plus 0% per visit thereafter, no Deductible applies in Office by Telehealth	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations	0% per visit No Deductible applies	See benefit for description
• Adult Immunizations	0% per visit No Deductible applies	See benefit for description
• Routine Gynecological Services/Well Woman Exams*	0% per visit No Deductible applies	See benefit for description
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	0% per visit No Deductible applies	See benefit for description
• Sterilization Procedures for Women*	0% per visit No Deductible applies	See benefit for description

• Vasectomy	Covered based on type of service and where it is received	See benefit for description
• Bone Density Testing*	0% per visit No Deductible applies	See benefit for description
• Screening for Prostate Cancer	0% per visit No Deductible applies	See benefit for description
• All other preventive services required by USPSTF and HRSA	Covered based on type of service and where it is received	See benefit for description
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered according to the type of benefit and the place where the service is received	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% per trip after Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	20% per trip after Deductible	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	$400 plus 0% per visit thereafter, no Deductible applies	See benefit for description
Urgent Care Center	$75 plus 0% per visit thereafter, no Deductible applies	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	$20 plus 0% per visit thereafter, no Deductible applies	See benefit for description 10 visits per Plan Year

Advanced Imaging Services • Performed in a Specialist Office	20% per visit after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	20% per visit after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization required**	20% per visit after Deductible	
Allergy Testing and Treatment • Performed in a PCP; physician Office	$20 plus 0% per visit thereafter, no Deductible applies	See benefit for description
• Performed in a Specialist Office	$65 plus 0% per visit thereafter, no Deductible applies	
Ambulatory Surgical Center Facility Fee **Preauthorization required**	20% per visit after Deductible	See benefit for description
Anesthesia Services (all settings)	Covered according to the type of benefit and the place where the service is received	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office	$65 plus 0% per visit thereafter, no Deductible applies	See benefit for description
• Performed as Outpatient Hospital Services	20% per visit after Deductible	
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital service Cost-Sharing	

Chemotherapy and Immunotherapy • Administration ○ Performed in a PCP; physician Office	$20 plus 0% per visit thereafter, no Deductible applies	See benefit for description
○ Performed in a Specialist Office	$65 plus 0% per visit thereafter, no Deductible applies	
• Performed as Outpatient Hospital Services	20% per visit after Deductible	
• Performed at Home	20% per visit after Deductible	
• Chemotherapy and Immunotherapy Medications	Covered according to the type of benefit and the place where the service is received	
Chiropractic Services	$65 plus 0% per visit thereafter, no Deductible applies	See benefit for description
Clinical Trials	Covered according to the type of benefit and the place where the service is received	See benefit for description
Diagnostic Testing • Performed in a PCP; physician Office	20% per visit after Deductible	See benefit for description
• Performed in a Specialist Office	20% per visit after Deductible	
• Performed as Outpatient Hospital Services	20% per visit after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP; physician Office	0% per visit, no Deductible applies	See benefit for description
• Performed in a Specialist Office	0% per visit, no Deductible applies	
• Performed in an Outpatient Facility	0% per visit, no Deductible applies	

Home Health Care **Preauthorization required**	0% per visit, no Deductible applies	See benefit for description 120 visits per Plan Year
Infertility Services **Preauthorization required**	Covered based on type of service and where it is received	See benefit for description
Infusion Therapy • Administration • Performed in a PCP; physician Office	$65 plus 0% thereafter, no Deductible applies	See benefit for description
• Performed in Specialist Office	$65 plus 0% thereafter, no Deductible applies	
• Performed as Outpatient Hospital Services	20% per visit after Deductible	
Home Infusion Therapy **Preauthorization required**	$65 plus 0% thereafter, no Deductible applies	
Inpatient Medical Visits **Preauthorization required**	20% per visit after Deductible	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions	0% per admission, no Deductible applies	Unlimited
• Elective Abortions	0% per admission, no Deductible applies	One (1) procedure per Plan Year
Laboratory Procedures • Performed in a PCP; physician Office	20% per visit after Deductible	See benefit for description
• Performed in a Specialist Office	20% per visit after Deductible	
• Performed in a Freestanding Laboratory Facility	20% per visit after Deductible	

• Performed as Outpatient Hospital Services	20% per visit after Deductible	
Maternity and Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	0% per visit, no Deductible applies	See benefit for description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered according to the type of benefit and the place where the service is received	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Inpatient Hospital Services	Covered according to the type of benefit and the place where the service is received	
• Physician and Midwife Services for Delivery	Covered according to the type of benefit and the place where the service is received	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	0% per visit, no Deductible applies	Covered for duration of breast feeding
• Postnatal Care **Preauthorization required for inpatient services; breast pump**	Covered according to the type of benefit and the place where the service is received	
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	20% per visit after Deductible	See benefit for description
Preadmission Testing	Covered based on type of service and where it is received	See benefit for description

Prescription Drugs Administered in Office or Outpatient Facilities • Administration • Performed in a PCP; physician Office	$20 plus 0% per visit thereafter, no Deductible applies	See benefit for description
• Performed in Specialist Office	$65 plus 0% per visit thereafter, no Deductible applies	
• Performed in Outpatient Facilities **Preauthorization required**	20% per visit after Deductible	
Diagnostic Radiology Services • Performed in a PCP; physician Office	20% per visit after Deductible	See benefit for description
• Performed in a Specialist Office	20% per visit after Deductible	
• Performed in a Freestanding Radiology Facility	20% per visit after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization required**	20% per visit after Deductible	
Therapeutic Radiology Services • Performed in a Specialist Office	20% per visit after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	20% per visit after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization required**	20% per visit after Deductible	

Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP; physician Office	20% per visit after Deductible	60 visits per Plan Year combined therapies
• Performed in a Specialist Office	20% per visit after Deductible	
• Performed in an Outpatient Facility	20% per visit after Deductible	
Retail Health Clinic Care	$20 plus 0% per visit thereafter, no Deductible applies	See benefit for description
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$65 plus 0% per visit thereafter, no Deductible applies	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) • Inpatient Hospital Surgery	20% per admission after Deductible	See benefit for description **All transplants must be performed at designated Centers of Excellence Facilities**
• Outpatient Hospital Surgery	20% per visit after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	20% per visit after Deductible	
• Office Surgery **Preauthorization required**	20% per visit after Deductible	
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	$20 plus 0% per visit, no Deductible applies	See benefit for description

Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization required**	50% per device after Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin	Covered according to the type of benefit and the place where the service is received **But not more than $100 for a 30-day supply of insulin.**	See benefit for description See Prescription Drug benefit for prescription drugs
• Diabetic Education	Covered according to the type of benefit and the place where the service is received	
Durable Medical Equipment and Braces	50% per device after Deductible	See benefit for description
External Hearing Aids	20% per device after Deductible	Single purchase once every one to three (3) years
Cochlear Implants **Preauthorization required**	Covered based on type of service and where it is received	One (1) per ear per time Covered
Hospice Care • Inpatient **Preauthorization required**	20% per admission after Deductible	Unlimited days per calendar year Five (5) visits for family bereavement counseling
• Outpatient **Preauthorization required**	20% per visit thereafter after Deductible	
Medical Supplies	Covered based on type of service and where it is received	See benefit for description

Prosthetic Devices • External • Internal **Preauthorization required**	50% per device after Deductible 50% per device after Deductible	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	20% per visit after Deductible	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 29 of the Public Health Law.**	20% per admission, after Deductible	See benefit for description
Observation Stay	20% per admission, after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required.**	20% per admission after Deductible	60 days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	20% per visit after Deductible	Unlimited days per Plan Year combined therapies

Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	20% per visit after Deductible	Unlimited days per Plan Year combined therapies
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required However, Preauthorization is not required for emergency admissions or for admissions at Participating OHM-licensed Facilities for Members under 18.**	20% per admission after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits	$20 plus 0% per visit thereafter, no Deductible applies in Office by Telehealth	See benefit for description
• All Other Outpatient Services **Preauthorization required**	0% per visit, no Deductible applies	
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	20% per admission after Deductible	See benefit for description

Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits	$20 plus 0% per visit thereafter, no Deductible applies in Office by Telehealth	Up to 20 visits may be used for family counseling
• All Other Outpatient Services **Preauthorization required** **However, Preauthorization is not required for Participating OASAS-certified Facilities.**	0% per visit, no Deductible applies	

PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30-day supply Tier 1 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	Copayment is the lesser of $10 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 2 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	Copayment is the lesser of $45 or the Allowed Amount per supply after Deductible	See benefit for description

Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	Copayment is the lesser of $80 or the Allowed Amount per supply after Deductible	See benefit for description
	The Deductible does not apply to certain Prescription Drugs. Visit Our website at https://www.aetna.com to review Our formulary or call the number on Your ID card to learn more.	
	The member out-of-pocket for prescription insulin drugs shall not exceed $100 per 30-day supply.	
Up to a 90-day supply for Maintenance Drugs Tier 1	Copayment is the lesser of $20 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 2	Copayment is the lesser of $90 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 3	Copayment is the lesser of $160 or the Allowed Amount per supply after Deductible	See benefit for description
	The Deductible does not apply to certain Prescription Drugs. Visit Our website at https://www.aetna.com to review Our formulary or call the number on Your ID card to learn more.	
Mail Order Pharmacy		
Up to a 30-day supply Tier 1	Copayment is the lesser of $10 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 2	Copayment is the lesser of $45 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 3	Copayment is the lesser of $80 or the Allowed Amount per supply after Deductible	See benefit for description
	The Deductible does not apply to certain Prescription Drugs. Visit Our website at https://www.aetna.com to review Our formulary or call the number on Your ID card to learn more.	
	The member out-of-pocket for prescription insulin drugs shall not exceed $100 per 30-day supply.	

Up to a 90-day supply Tier 1	Copayment is the lesser of $20 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 2	Copayment is the lesser of $90 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 3	Copayment is the lesser of $160 or the Allowed Amount per supply after Deductible	See benefit for description
	The Deductible does not apply to certain Prescription Drugs. Visit Our website at https://www.aetna.com to review Our formulary or call the number on Your ID card to learn more.	
Enteral Formulas	0% per supply after Deductible	See benefit for description

Aetna Life Insurance Company

CVS Pharmacy Rider

Policyholder: Aspen HR PEO, LLC

Group policy number: GP-0175126

Rider effective date: September 1, 2022

Your health plan has changed. The Certificate is revised to reflect this. This change is effective on the date shown above.

1. The option of CVS pharmacy has been added to the *Refills* provision of the *Prescription Drug Coverage* section of the Certificate of Coverage as follows:

   We Cover Refills of Prescription Drugs when dispensed at a mail order or CVS pharmacy as ordered by an authorized Provider. Each Prescription is limited to a maximum 90 day supply.

2. The option of CVS pharmacy has been added to the Mail Order provision of the *Prescription Drugs* section of the Schedule of Benefits as follows:

Mail Order Pharmacy or CVS		
Up to a 30-day supply Tier 1	Copayment is the lesser of $10 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 2	Copayment is the lesser of $45 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 3	Copayment is the lesser of $80 or the Allowed Amount per supply after Deductible	See benefit for description
	The Deductible does not apply to certain Prescription Drugs. Visit Our website at https://www.aetna.com to review Our formulary or call the number on Your ID card to learn more.	
	The member out-of-pocket for prescription insulin drugs shall not exceed $100 per 30-day supply.	

Up to a 90-day supply Tier 1	Copayment is the lesser of $20 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 2	Copayment is the lesser of $90 or the Allowed Amount per supply after Deductible	See benefit for description
Tier 3	Copayment is the lesser of $160 or the Allowed Amount per supply after Deductible	See benefit for description
	The Deductible does not apply to certain Prescription Drugs. Visit Our website at https://www.aetna.com to review Our formulary or call the number on Your ID card to learn more.	

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.

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

CVS Pharmacy
Rider 001
Issue Date September 1, 2022

Aetna Life Insurance Company

Gene Therapy Rider

Policyholder: Aspen HR PEO, LLC

Group policy number: GP-0175126

Rider effective date: September 1, 2022

Your health plan has changed. The Certificate and Schedule of Benefits are revised to reflect this. This change is effective on the date shown above.

1. *Gene-based, cellular and other innovative therapies (GCIT)* provision has been added to the *Therapies* provision in the Certificate:

Gene-based, cellular and other innovative therapies (GCIT)
Covered Services include GCIT provided by a Physician, Hospital or other Provider.

Key Terms
Here are some key terms We use in this section. These will help You better understand GCIT.

Gene
A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular
Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic
Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:
- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not Covered under the Institutes of Excellence™ (IOE) programs. We call these “GCIT services.”

GCIT Covered Services include:
- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.

- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies
We designate Facilities to provide GCIT services or procedures. GCIT Physicians, Hospitals and other Providers are GCIT-designated Facilities/Providers for Aetna and CVS Health.

Important note:
You must get GCIT Covered Services from a GCIT-designated Facility/Provider. If there are no GCIT-designated Facilities/Providers assigned in Your network, it's important that You contact Us so We can help You determine if there are other Facilities that may meet Your needs. If You don't get Your GCIT services at the Facility/Provider We designate, they will not be Covered Services.

2. *Gene-based, cellular and other innovative therapies (GCIT)* provision has been added to the Schedule of Benefits:

Gene-based, cellular and other innovative therapies (GCIT)

	Participating Provider Member Responsibility for Cost-Sharing	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Services and Supplies **Preauthorization required**	Covered based on type of service and where it is received	Non-Participating Provider services are not Covered and You pay the full cost	

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.

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

Gene Therapy
Rider 002
Issue Date September 1, 2022

Aetna Life Insurance Company

Aetna's National Infertility Unit Rider

Policyholder: Aspen HR PEO, LLC

Group policy number: GP-0175126

Rider effective date: September 1, 2022

Your health plan has changed. The Certificate is revised to reflect this. This change is effective on the date shown above.

Aetna's National Infertility Unit has been added to the *Outpatient and Professional Services* section under *Infertility Treatment – Comprehensive Infertility Services* provision of Your health plan as follows:

> **Aetna's National Infertility Unit**
> The first step to using Your Comprehensive Infertility 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 Preauthorization. You can call the NIU at 1-800-575-5999.

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.

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

National Infertility Unit
Rider 003
Issue Date September 1, 2022

Aetna Life Insurance Company

Oral Surgery Rider

Policyholder: Aspen HR PEO, LLC

Group policy number: GP-0175126

Rider effective date: September 1, 2022

Your health plan has changed. The Certificate of Coverage is revised to reflect this. This change is effective on the date shown above.

The *Oral Surgery* provision has been added to the *Outpatient and Professional Services* section of Your Certificate as follows:

Oral Surgery
We cover the following limited dental and oral surgical procedures:

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

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.

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

Oral Surgery
Rider 004
Issue Date: September 1, 2022

Aetna Life Insurance Company

Private Duty Nursing Rider

Policyholder: Aspen HR PEO, LLC

Group policy number: GP-0175126

Rider effective date: September 1, 2022

Your health plan has changed. The Certificate is revised to reflect this. This change is effective on the date shown above.

1. The *Private Duty Nursing* provision has been added to the *Outpatient and Professional Services* section of Your Certificate as follows:

   Covered Services include private duty nursing care, ordered by a Physician and provided by an R.N. or L.P.N. when:
   - You are homebound
   - Your Physician orders services as part of a written treatment plan
   - Services take the place of a Hospital or Skilled Nursing Facility stay
   - Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
   - Periodic skilled nursing visits are not adequate

   The following are not Covered Services:
   - Inpatient private duty nursing care
   - Care provided outside the home
   - Maintenance or custodial care
   - Care for Your convenience or the convenience of the family caregiver

2. *Private Duty Nursing* has been added to the *Outpatient and Professional Services* provision of the Schedule of Benefits as follows:

	Participating Provider Member Responsibility for Cost-Sharing	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Private Duty Nursing Up to eight hours equals one shift	20% per visit after Deductible **Preauthorization required**	Not applicable Not applicable	
Visit/shift limit per year	70 visits	Not applicable	

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.

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

Private Duty Nursing
Rider 005
Issue Date September 1, 2022

Aetna Life Insurance Company

No Surprises Act Rider

This rider amends the sections listed below of Your Certificate to provide the consumer protections required under the Federal No Surprises Act.

1. Paragraph C from How Your Coverage Works section is replaced with the following:

C. Participating Providers.
To find out if a Provider is a Preferred or Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website www.aetna.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Provider is a Preferred Provider; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any Copayment, Deductible or Coinsurance that would apply to the Covered Services, and You are not responsible for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one business day of Your telephone request for network status information.

2. Paragraph N from How Your Coverage Works section is replaced with the following:

N. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
    - For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
        - A participating Provider is unavailable at the time the health care services are performed;
        - A non-participating Provider performs services without Your knowledge; or
        - Unforeseen medical issues or services arise at the time the health care services are

performed.

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

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
  - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
  - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. You can sign a form to let Us and the Non-Participating Provider know You received a surprise bill.

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

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

3. Paragraph E from the Access to Care section is replaced with the following:

E. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, Referrals; authorizations, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Copayment, Deductible or Coinsurance. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

4. A new paragraph is added to the Ambulance and Pre-Hospital Emergency Medical Services as follows:

Payments for Air Ambulance Services. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance service or the Non-Participating Provider's charge. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

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

You are responsible for any Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us. Visit Our website at www.aetna.com or www.dfs.ny.gov for more information on the independent dispute resolution process for air ambulance bills.

5. Item 3 under Paragraph A titled "Emergency Services" in the Emergency Services and Urgent Care section is replaced with the following:

3. Payments Relating to Emergency Services. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service or the Non-Participating Provider's charge. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

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

You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us.

6. Controlling Certificate.
All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

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

No Surprises Act
Rider 006
Issue Date: September 1, 2022

Additional Information Provided by

Aspen HR PEO, LLC

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

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

Name of Plan:
Aspen HR's Health & Welfare Plan

Employer Identification Number:
85-3188438

Plan Number:
501

Type of Plan:
Health and Welfare Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Aspen HR PEO, LLC
750 Battery Street 6th Floor
San Francisco, CA 94111
Telephone Number: (415) 420-4153

Agent For Service of Legal Process:
Aspen HR PEO, LLC
750 Battery Street 6th Floor
San Francisco, CA 94111

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

End of Plan Year:
August 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by Chief Financial Officer, Chief Operating Officer.

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

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

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

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

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

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

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

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

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

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

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

Assistance with Your Questions

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

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

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Important disclosure information about New York large group plans

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and Aetna Health Insurance Company of New York and affiliates (Aetna).

Table of contents

Here is important disclosure information about our plans. It's followed by required New York content. If there is any difference between this disclosure and your plan documents, the plan documents govern.

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit **Aetna.com/ individuals-families-health-insurance/document- library/documents/2019Disclosures/NCQA-MED- Disclosures-FI-SI.pdf** to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

Know the costs and rules for using your plan

- What you pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a large group plan

If you're a member, not all of the information in this document applies to your specific plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our provider network

To find a network provider, sign in to **Aetna.com** and select "Find Care" from the top menu bar to start your search. To learn more about how we pay out-of-network benefits when a plan allows them, visit **Aetna.com** and type "how Aetna pays" into the search box.

Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your member ID card.

No coverage based on U.S. trade sanctions

If U.S. trade sanctions consider you a "blocked person," the plan can't provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan, in most cases, can't provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we can't pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan can't pay for those services. For more information, visit **Treasury.gov/resource-center/sanctions/pages/ default.aspx** to read about U.S. trade sanctions.

Coverage for transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents. CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can visit **Aetna.com/health-care- professionals/clinical-policy-bulletins.html** to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

Member rights and responsibilities

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care and to serve you better.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents. Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan. If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

For more information:

- Call the number on your member ID card
- Visit the U.S. Department of Labor at **DOL.gov/sites/ dolgov/files/ebsa/about-ebsa/our-**activities**/ resource-center/publications/your-rights-after-a- mastectomy.pdf**

Your right to enroll later

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

Important information for New York plans

Type of insurance coverage

Aetna's large group plans are considered commercial insurance plans under New York Law. Our large group plans offer comprehensive health insurance coverage. Check your selected plan of benefits to see if you have out of network benefits.

Using your NY plan

You can choose any primary care provider (PCP) who participates in the Aetna network and who is accepting new patients.

A PCP may be a general practitioner, family physician, internist or a pediatrician. Each covered family member may select his or her own PCP. Your PCP provides routine preventive care and will treat you for illness or injury. Your PCP may refer you to other network doctors and hospitals for covered services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization. The online provider directory indicates whether a provider is accepting new patients. You can also ask the provider's office to confirm when scheduling an appointment.

Tell us who you chose to be your PCP

Each member of the family may chose a different PCP from the Aetna network. Enter the ID number of the PCP you choose on your enrollment form.

You can change your PCP or specialist at any time. Log in at **Aetna.com** or call the Member Services toll-free number on your Aetna ID card. The change will become effective when we receive and approve the request.

Making your specialist your PCP

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition, who will be responsible for and capable of providing and coordinating your primary and specialty care. This referral will be issued based on a treatment plan that is approved by Aetna, in consultation with the primary care provider if appropriate, the specialist, and you or your authorized representative.

Please call Member Services at the toll-free number in your ID card or call **1-888-982-3862 (TTY: 711)** to request these services.

Direct Access Ob/Gyn program

This program allows female members direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such examinations, and treatment of acute gynecologic conditions, including care for pregnancy- related services, from a qualified participating provider of the member's choice.

Direct specialist care for life threatening conditions If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center or to a specialist responsible for providing or coordinating your medical care. To request these services, please call Member Services at the toll-free number on your ID card or call **1-888-982-3862 (TTY: 711)**.

Referrals: Your PCP will refer you to a specialist when needed

You never need to get a referral if you have an Aetna Open Access® Managed Choice, Aetna Open Access® Elect Choice or Open Choice® plan. With the Managed Choice plan, you will receive the highest level of benefits under the plan when you get a referral from your PCP before you see a network specialist.

A referral is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved. Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Getting a referral from your PCP is not the same as getting approval (called precertification) from the plan. Some health care services require both. For more information, read the "Precertification: getting approvals for services" section of this booklet.

Remember these points about referrals:

- You do not need a referral for emergency care or urgent care.

- If you do not get a referral when required, the plan will pay for the service as an out-of-network benefit, if available.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an ob/gyn without a referral. See "Direct Access Ob/Gyn program."
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. See the "Precertification: getting approvals for services" section for details.

Referrals within physician groups
Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services.
And you may need permission from the physician group as well.

Out-of-network referrals
If a covered service you need isn't available from a network provider or facility with the training or expertise needed for your condition, or if a participating provider is not geographically accessible, your PCP may refer you to an out-of-network provider. Your PCP or other network provider must get preapproval from Aetna and issue a special nonparticipating referral for services from out-of-network providers to be covered.

Standing referrals
If you have a condition that requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist.

You don't need a PCP referral for:

- Emergency care — see the "Emergency care" section to learn more
- Urgent care — see the "Emergency care" section to learn more
- Direct access services — certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the "What the Plan Covers" and the "Summary of Benefits" sections of your plan documents. You can directly access these network specialists for:
- Routine gynecologist visits
- Routine eye exams in accordance with the schedule
- An annual screening mammogram for age-eligible women
- Routine prenatal care (precertification may be required)

Precertification: getting approvals for services Sometimes we will pay for care only if we have given an approval before you get it. We call that precertification or preauthorization. We usually only need to pre-certify more serious care like surgery or being admitted to a hospital. Your PCP or Aetna network doctor will get this approval for you. If the request is to go outside the network, you may have to get this approval yourself. To do so, call the precertification number on your Aetna ID card, **1-877-204-9186 (TTY: 711)**, or send your request to:

Aetna
1425 Union Meeting Road Blue Bell,
PA 19422

You must get the precertification before you receive the care. Your plan documents list all the services that require you to get precertification. If you don't have a service pre-certified when required, you may incur a penalty. Please see your plan documents for more information.

Prospective reviews
We'll notify your doctor within three business days If we have all the information necessary to review the request, we will make our decision and notify you (or your designee) and your doctor, by telephone and in writing, within three business days of receipt of the necessary information.

If we need more information, we will request it within three calendar days. You or your doctor will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make our decision and notify you (or your designee) and your doctor, by telephone and in writing, within three business days of our receipt of the information. If we do not receive all necessary information within 45 days, we will make our decision within 15 calendar days of the end of the 45-day period.

Time frames for urgent care requests
If we have all information necessary to make a decision, we will do so and notify you (or your designee) and your doctor, by telephone and in writing, within 72 hours of receipt of the request. If we need more information, we will ask for it within 24 hours. You or your doctor will then have 48 hours to submit the information. We will make our decision and notify you and your doctor, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

Time frames for home care services
After receiving a request for coverage of home care services following an inpatient hospital admission, we will make our decision and notify you (or your designee) and your provider, by telephone and in writing, within one business day of our receipt of the necessary information. If the day after the request falls on a weekend or holiday, we'll notify you within 72 hours of receipt of the necessary information. We will not deny coverage for home care services while our decision is pending.

Time frames for rehabilitation service requests, following an inpatient hospital stay

Starting January 1, 2021, we'll make a decision upon receipt of all necessary information within one business day. We'll notify you (or your designee) and your doctor of the decision.

Time frame for inpatient substance use disorder treatment
If we receive a request for coverage of inpatient substance use disorder treatment at least 24 hours prior to discharge from an inpatient hospital admission, we will make our decision and notify you (or your designee) and your provider, by telephone and in writing, within 24 hours of our receipt of the necessary information. We will not deny coverage for the treatment while our decision is pending.

What we look for when reviewing a precertification request
First, we check to see that you are still a member. And we make sure the service is a covered expense under your plan. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to your doctor about it. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

We follow up on services we precertify
There are other steps to our utilization review process. These include:

Concurrent review: We begin this process if your hospital stay lasts longer than what was approved for coverage. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting. We will notify you or your doctor of our decision of whether to continue covering your hospital stay. Utilization review decisions for services during the course of care (concurrent reviews) will be made and notice provided to you (or your designee) or your provider, by telephone and in writing, within one business day of receipt of all necessary information. If we need additional information, we will request it within 24 hours. You or your provider will then have at least 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) or your provider, by telephone and in writing, within the earlier of: (a) one business day of the receipt of necessary information, or (b) the end of the time period allotted to provide the clinical information.

Discharge planning: We begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you're home.

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits for the member after they are released from the inpatient facility.

Retrospective review: We review the claim for services after you are discharged. We may look over your medical records and claims from your doctors and the hospital. We look to see that you received appropriate care and if there was any waste or unnecessary costs. We may deny coverage if the information presented is materially different from what was originally presented during the precertification process. If we deny coverage, we will tell you and your doctor within 30 days.

If we need additional information, we will request it within 30 calendar days. You or your doctor will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period. If we have all the necessary information and fail to make a determination within the applicable time frames, you may consider this a denial and file an appeal.

To contact the utilization review agent, call the precertification number on your Aetna ID card or **1-877-204-9186** weekdays from 8 AM to 5 PM ET. After hours, you can leave a message. If your doctor has a question about your coverage, your doctor or you may write to or call our Patient Management department at the address or phone number on your Aetna ID card.

Your doctor can ask us to reconsider a denial if we did not attempt to communicate with them first. For precertification and concurrent reviews, your doctor can request a reconsideration review. We will reconsider the denial within one business day. If we uphold the denial, we will notify you and your doctor in writing with appeal instructions. See "What to do if you disagree with us" to learn more.

We may deny coverage for a previously precertified treatment, service or procedure if:

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

Member payment estimator tool for New York members
If a service or procedure is not listed in the member payment estimator tool on your member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate form on our website.

Please visit the state information section at **Aetna.com/ individuals-families/member-rights-resources/ rights/state-specific-information.html** for the form or to link to an online price estimator tool.

An "out of network" doctor is one with whom we do not have a contract for discounted rates. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to see an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes, or allows. Your doctor may bill you for the dollar amount the plan doesn't recognize. You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90 percent of Medicare (that is, 10 percent less than Medicare would pay) to 300 percent of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the usual

and customary charge or reasonable amount rate. These plans use information from FAIR Health, Inc. (**Fairhealth.org**), which is a not-for-profit company that reports how much providers charge for services in any ZIP code.

When you choose to enroll in a plan with out-of-network coverage, you should consider how plans based on Medicare rates compare to plans based on "usual and customary" charges. Roughly speaking, in New York for all services combined, 300 percent of Medicare rates are the same as the usual and customary charges.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you choose to get care out of network.

Emergency care
If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is defined as a medical or behavioral condition that produces symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

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

Treatment for an emergency medical condition is not subject to prior approval. However, whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

Call the local emergency hotline (ex. **911**) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.

If you are admitted to an inpatient facility, you or a family member or friend acting on your behalf should notify your PCP or Aetna as soon as possible.

Covered expenses for emergency medical conditions are payable in accordance with your plan. Please refer to your summary of benefits for the applicable copay, deductible and coinsurance amounts that apply.

Urgent care
Care for certain conditions (such as severe vomiting, earaches, sore throats or fever) is considered "urgent care." You can get urgent care from your PCP or an urgent care facility. If you're traveling outside your Aetna service area or if you are a student who is away at school, you are covered for any urgently needed care rendered by any licensed physician or facility.

Claims for emergency care
We'll review the information when the claim comes in. If we think the situation was not an emergency, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone. Emergency care expenses that are not related to an emergency medical condition are excluded and are your financial responsibility.

If we don't agree on rates for out-of-network emergency care, Aetna, non-participating physicians and hospitals can file arbitration, known as independent dispute resolution. Your in-network cost share may go up if we need to pay more on an emergency claim if we settle or arbitration is filed after the initial payment.

Follow-up care for plans that require a PCP

Your PCP should coordinate any follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care
You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating urgent care facilities.

We check if it's medically necessary

A medically necessary service or supply is one that is provided by a doctor who exercises prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms; the provision of the service or supply is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease
- Not primarily for your convenience or that of your treating physician
- Not more costly than an alternative service or sequence of services that is at least as likely to produce the same or similar therapeutic or diagnostic results

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Important note: Not every service, supply or prescription drug that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your plan documents and Schedule of Benefits for the plan limits and maximums.

All determinations that services are not medically necessary will be made by licensed physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and the same or similar specialty as the health care provider who typically manages your medical condition or disease or provides the health care service under review.

For purposes of a determination involving substance use disorder treatment, services that are not medically necessary will be provided by:

(i) A physician who possesses a current and valid nonrestricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment

(ii) A health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid nonrestricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession

We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit **Aetna.com/about/cov_det_policies. html** to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card.

We study the latest medical technology
We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in

line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies.

To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective any treatments and technologies are.
- See what other medical and government groups say about treatments and technologies. That includes the federal Agency for Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully treatments and technologies have been used.

We publish our decisions in our Clinical Policy Bulletins.

How to file a claim

For most services, network doctors will file your claims for you. If you go outside the network, you may need to file claims yourself. Your health care professional may file a claim within 120 days from the date of service. You may also file a claim yourself.

We accept claims by mail, fax and electronically. If you need to file a claim with us, please call Member Services at the number on your Aetna ID card. The representative will give you the mailing address, email address or fax number for our claims office. You can also log in to your member website at **Aetna.com** to download a claim form (which includes the mailing address) or to send the claim electronically. To send the claim electronically, log in to **Aetna.com** and click "Contact" in upper right corner. You can submit a claim form as an attachment.

Our plans comply with mental health laws

We want you to know that our plans comply with all federal and NY state requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes the non-quantitative treatment limitation (NQTL) requirements applied to behavioral health and substance use disorder benefits. We use the same processes and standards to determine these requirements as those we use to determine requirements for medical and surgical treatments. In other words, we apply the same medical management requirements, such as precertification, to all plan benefits, including:

- Behavioral health
- Substance use disorder
- Medical and surgical treatments

If you'd like to see how we arrive at the NQTL requirements, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

How we determine cost share

To ensure that we comply with federal and state mental health laws regarding members' cost share, we apply certain test measures laid out in the federal law. These are called the "substantially all" and "predominant level" tests. If you'd like to see how we arrive at members' cost share, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

Grievances: What to do if you disagree with us

Please tell us if you are not satisfied with a response you received from us or with how we do business. A grievance is a complaint that does not involve a claim that was denied because it was not medically necessary. It does apply to contractual benefits denials, issues or concerns you have about our administrative policies, or access to doctors.

Here is a summary of the grievance processes.

Call the toll-free number on your Aetna ID card to file a verbal grievance or to ask for the address to mail a written grievance.

You can also email Member Services through the member website or write to us at the address on your Aetna ID card. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

You have the right to appoint a designee to handle your grievance.
You or your designee may file a grievance up to 180 calendar days from when you received the decision you are asking us to review. When we receive your grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling your grievance and indicate what additional information, if any, we need from you.

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

Qualified personnel will review your grievance in a timely manner. If it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following time frames:

Time frames for determining a grievance

Type of grievance	**Level 1 appeals**
Expedited/urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (a request for a service or treatment that has not yet been provided)	In writing, within 15 calendar days of receipt of your grievance
Postservice grievance (a claim for a service or a treatment that has already been provided)	In writing, within 30 calendar days of receipt of your grievance
All other grievances (those that are not in relation to a claim or request for service)	In writing, and depending on your plan, either within 30 or 45 calendar days of receipt of your grievance, or within 45 calendar days of receipt of all Necessary information, but no More than 60 calendar days Of receipt of your grievance. See your plan documents for time frames that apply to your specific plan.

Grievance appeals
If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone, in person or in writing. You may file an urgent appeal by phone. You have up to 60 business days from receipt of our decision to file an appeal.

When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your appeal. If necessary, it will also inform you of any additional information we may need to make a decision. One or more qualified personnel at a higher level than the person who rendered the complaint decision will review the appeal. If it is a clinical matter, a clinical peer reviewer will look into it.

Time frames for determining your appeal of a grievance determination:

Type of grievance	Level 1 appeals
Expedited/urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (a request for a service or treatment that has not yet been provided)	The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your appeal
Postservice grievance (a claim for a service or a treatment that has already been provided)	30 calendar days of receipt of your appeal
All other grievances (those that are not in relation to a claim or request for service)	Depending on your plan, either 30 business days of receipt of all necessary information to make a determination, or 30 calendar days of receipt of your appeal. See your plan documents for time frames that apply to your specific plan.

If you are not satisfied or if you need help
If you are not satisfied with our appeal determination, or at any other time you are dissatisfied, you may call the New York State Department of Financial Services at **1-800-342-3736** or write them at:

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

If you need help fling a grievance or appeal, you may also contact the state independent consumer assistance program at:

Community health Advocates
105 East 22nd Street
New York, NY 10010
Call toll-free: 1-888-614-5400
Email: **cha@cssny.org**
Website: **CommunityHealthAdvocates.org**

Internal appeals for utilization review determinations

You have the right to appoint a designee to handle your appeal. You, your designee and, in retrospective cases, your doctor, may request an internal appeal if we deny a previously precertified service or make other adverse determinations based on utilization review. You may submit your appeal by phone, in person or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before we can make a decision. A qualified clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal

First-level appeal Precertification appeal
If your appeal relates to a service that requires prior approval and the services have not yet been rendered, we will decide the appeal within 15 calendar days of receipt of the appeal request.

Retrospective appeal
If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request.

Expedited appeal
An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two business days of receipt of the information necessary to conduct the appeal.

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

Our failure to render a determination of your appeal within the applicable time frame will be deemed a reversal of the initial adverse determination.

Substance use disorder appeal
If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal appeal of our adverse determination, we will decide the appeal within 24 hours of receipt of the appeal request. If you or your provider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of our adverse determination, we will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

Second-level appeal
If you disagree with the first-level appeal determination, you or your designee can file a second-level appeal. You or your designee can also file an external appeal. The four-month time frame for filing an external appeal begins on receipt of the final adverse determination on the first level of appeal. By choosing to file a second-level appeal, the time may expire for you to file an external appeal.

A second-level appeal must be filed within 60 days of receipt of the final adverse determination on the first-level appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and inform you, if necessary, of any additional information needed before a decision can be made.

If your appeal relates to a service that requires prior approval and the services have not yet been rendered, we will decide the appeal within 15 calendar days of receipt of the appeal request.
If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request.

If your doctor thinks you cannot wait, you can request an expedited appeal
If you are not satisfied with the resolution of an expedited appeal, you may file a standard internal appeal or an external appeal. You may file an expedited external appeal at the same time you file an expedited internal appeal. See the "External review" section for more.

External appeal

A. Your right to an external appeal
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals. In order for You to be eligible for an external appeal, You must meet the following two (2) requirements:

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

B. Your right to appeal a determination that a service is not medically necessary
If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your right to appeal a determination that a service is experimental or investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

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

In addition, Your attending Physician must have recommended one (1) of the following:

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

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

D. Your right to appeal a determination that a service is out-of-network

If We have denied coverage of an out-of-network treatment because it is not materially different from the health service available in network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above and You have requested Preauthorization for the out-of-network treatment.

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

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

E. Your right to appeal an out-of-network referral denial to a non-participating provider

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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

F. Your right to appeal a formulary exception denial

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The external appeal process

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

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

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

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

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

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your

designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application.

If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

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

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

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

H. Your responsibilities

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

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

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 60 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 60 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

More information is available upon request

In accordance with New York law, the following information is available to a member or prospective member upon request by contacting the Member Services department:

(1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners

or partners of the plan

(2) The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant

(3) A copy of the most recent individual conversion, direct-pay subscriber contracts

(4) Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law

(5) Procedures for protecting the confidentiality of medical records and other enrollee information

(6) Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs

(7) Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program

(8) A description of the procedures followed in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials

(9) Individual health practitioner affiliations with participating hospitals, if any

(10) Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information the plan might consider in its patient management program; the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan.

Member Services can help you with this request by calling the number on your Aetna ID card. You can also send a request to Aetna by writing to:

Aetna
Attn: CRC Requests 1800 E Interstate Ave
Bismarck, ND 58503

(11) Written application procedures and minimum qualification requirements for health care providers considered by the plan

(12) Such other information as required by the Superintendent of Insurance provided that such requirements are promulgated pursuant to the state administrative procedure act

(13) If you are scheduled to receive health care services, you can ask us if that health care provider participates in the plan's network

(14) The approximate dollar amount the plan will pay for a specific out-of-network health care service. This information is nonbinding and the approximate dollar amount for a specific out-of-network service may change.

Protection from surprise bills

A surprise bill is a bill you receive for covered services performed by a nonparticipating physician at a participating hospital or ambulatory surgical center, when:

- A participating physician is unavailable at the time the health care services are performed
- A nonparticipating physician performs services without your knowledge
- Unforeseen medical issues or services arise at the time the health care services are performed
- You were referred by a participating physician to a nonparticipating provider without your

explicit written consent acknowledging that the referral was to a nonparticipating provider and that the visit may result in costs not covered by us (a referral to a nonparticipating provider is defined as covered services performed by a nonparticipating provider in the participating physician's office or practice during the same visit)

- The participating physician sends a specimen taken from you in the participating physician's office to a nonparticipating laboratory or pathologist
- For any other covered services performed by a nonparticipating provider at the participating physician's request, when referrals are required under your certificate

- A surprise bill does not include a bill for health care services when a participating physician is available and you elected to receive services from a nonparticipating physician.
- You will be held harmless for any nonparticipating provider charges for the surprise bill that exceed your in-network copayment, deductible or coinsurance if you assign benefits to the nonparticipating provider in writing. In such cases, the nonparticipating provider may only bill you for your in-network copayment, deductible or coinsurance.
- The medical benefits certification form for surprise bills is available on the next page or at **dfs.ny.gov**. You can also visit our website at **Aetna.com** for a copy of the form. You need to mail a copy of the medical benefits certification form or the assignment of benefits form to us at the address on your ID card and to your provider.
- You can call Member Services if you need help completing and sending the form. The phone number is on your Aetna ID card. You may mail the form to us at:

Member Correspondence
Aetna
PO Box 981106
El Paso, Texas 79998-1106

Or you can send the form electronically. Log in to

Aetna.com and click "Contact" in the upper right corner. You can submit the form as an attachment.

Independent dispute resolution process:

Either we or a provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at **dfs.ny.gov**. The IDRE will determine whether our payment or the provider's charge is reasonable within 30 days of receiving the dispute. You may also submit a dispute if you do not assign benefits or if you are uninsured.

NEW YORK STATE SURPRISE MEDICAL BILL CERTIFICATION FORM

You are protected from surprise medical bills. Your health plan must pay your health care provider, and your provider cannot bill you, except for any in-network cost-sharing.

- This form is required for surprise bills in (1) below for dates of service before 1/1/22 and for surprise bills in (2) below for all dates of service. This form is **NOT** required for surprise bills in (1) below for dates of service on and after 1/1/22 but helps identify when services are a surprise bill.
- Send a copy of this form to your **provider** and **health plan** (include a copy of any bill you received).
- Your provider may complete this form for a surprise bill described in (1) below for dates of service on and after 1/1/22, and your provider must send it to your **health plan**.

A surprise bill is when:

1. You're at an in-network hospital or ambulatory surgical facility and an in-network provider was not available; an out-of-network provider provided services without your knowledge; or you needed unforeseen medical services. Also, you did not choose to receive services from an out-of-network provider instead of from an available in-network provider before you went to the hospital or ambulatory surgical facility. (Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services in an in-network hospital or ambulatory surgical facility are usually a surprise bill.)
2. During a visit with your in-network doctor an out-of-network provider treats you; your in-network doctor takes a specimen from you and sends it to an out-of-network lab or pathologist; or your in-network doctor refers you to an out-of-network provider (and referrals are required under your health plan). Also, you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your health plan.

I certify to the best of my knowledge that (check one):

☐ I received services that are a surprise bill as described in (1) or (2) above and I want the provider to seekpayment for this bill from my health plan (this is an "assignment") **OR**

☐ I am a **health care provider**, and the insured received services that are a surprise bill as described in (1) abovefor dates of service on and after 1/1/22.

Patient Name:		**Date of Service:**	
Patient Mailing Address:			
Insurer Name:		**Insurance ID No:**	
Provider Name:		**Provider Phone Number:**	
Provider Mailing Address:			
Provider Contact Name (if different from provider name)			
Provider Contact Email Address:			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.			
Signature (of patient or provider):		**Date signed:**	

If you have questions about this form, contact the Department of Financial Services at (800) 342-3736.

NYS FORM SURPRISE BILL (12/30/21)

Out-of-network reimbursement examples for large group coverage

This summary gives examples of typical costs for out-of-network services under our three most commonly sold health insurance plans in New York County that include ZIP codes with the prefix 100, 101 and 102. If you want details about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-888-982-3862**.

Colonoscopy CPT4 codes
Procedure: 45380
Anesthesia: 00810
Pathology: 88305

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	$5,119	$3,916	$1,827	$1,827
Physician services	$1,600	$750	$350	$275
Anesthesia	$1,944	$417	$191	$150
Pathology	$263	$244	$114	$89
Total	**$8,926**	**$5,326**	**$2,482**	**$2,342**

Patient pays	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Deductible	$2,000	$2,000	$2,000
Copays	$50	$50	$50
Coinsurance	$983	$130	$88
Difference between UCR charge and what the plan pays	$6,632	$8,623	$8,722
Total	**$9,665**	**$10,803**	**$10,859**

Laminotomy CPT4 codes
Procedure: 63030
Anesthesia: 00630

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	$18,250	$3,158	$1,474	$1,474
Physician services	$35,000	$3,859	$1,801	$1,415
Anesthesia	$6,600	$1,668	$764	$600
Total	**$59,850**	**$8,685**	**$4,039**	**$3,489**

Patient pays	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Deductible	$2,000	$2,000	$2,000
Copays	$50	$50	$50
Coinsurance	$1,990	$597	$432
Difference between UCR charge and what the plan pays	$55,206	$58,458	$58,843
Total	**$59,246**	**$61,105**	**$61,325**

Breast Reconstruction CPT4 codes Procedure:
19357
Anesthesia: 00402

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	$64,501	$62,486	$29,160	$29,160
Physician services	$21,280	$5,616	$2,621	$2,059
Anesthesia	$4,596	$1,137	$521	$409
Total	**$90,377**	**$69,239**	**$32,302**	**$31,629**

Patient pays	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Deductible	$2,000	$2,000	$2,000
Copays	$50	$50	$50
Coinsurance	$20,157	$9,076	$8,874
Difference between UCR charge and what the plan pays	$12,818	$38,674	$39,145
Total	**$35,024**	**$49,799**	**$50,068**

The usual, customary and reasonable (UCR) charge is the amount providers typically charge for a service. This chart uses UCR charges based on FAIR Health at the 80th percentile for New York County ZIP codes with the prefix 100. Your provider may bill more than the UCR charge.
The "patient pays" column represents sample cost-sharing. Your cost-sharing may vary.
Notes: Colonoscopy provided out of network is not covered as a preventive service under the Affordable Care Act. Copayment is shown as $0 because copayments do not typically apply to out-of-network coverage.
These examples do not take into account whether the member's coinsurance is 30% and assumes the member's coinsurance limit has been met.

These examples only apply to plans with out-of-network coverage.
Claim examples assume services were done on an outpatient basis.
Sample cost examples:
Plan A = 300% Medicare for professional services, and 300% Medicare facility services
Plan B = 140% Medicare for professional services, and 140% Medicare facility services
Plan C = 110% Medicare for professional services, and 140% Medicare facility services
These samples were prepared in December 2019. UCR charges may change over time.

Aetna complies with applicable federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462,
Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD)**

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)

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

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

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

مقرلا بلع لاصتلا ءاجرلا ،ةفلكت يأ نود ةيوغللا تامدخلا بلع لوصحلل 1-888-982-3862 . (Arabic)

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

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

言語サービスを無料でご利用いただくには、1-888-982-3862　までお電話ください。(Japanese)

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

دیریگ سامت 1-888-982-3862 هرامش اب ،ناگیار روط هب نابز تامدخ هب یسرتسد یارب. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 . (Polish) Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862 . (Portuguese)

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

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

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Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.