BENEFIT PLAN

Prepared Exclusively For
PrideStaff, Inc.

Open Choice PPO HDHP

Extraterritorial Riders

Aetna Life Insurance Company

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

aetna™

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Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

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

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

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

Autism spectrum disorder

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

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

Eligible health services include:

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

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

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

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

Diabetic equipment, supplies and education

Eligible health services include:

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

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

Infertility services

Basic infertility

Covered services include seeing a **provider:**

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

Comprehensive infertility services

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

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

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

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

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

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

Aetna's National Infertility Unit

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

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

Advanced reproductive technology (ART)

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

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.

- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)
- Oral and injectable **prescription** drugs used:
  - To stimulate the ovaries
  - Primarily for treating the underlying cause of **infertility**

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

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

You are eligible for ART services if:

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

Aetna's National Infertility Unit

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

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

Fertility preservation

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

Covered services for fertility preservation are provided when:

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

Premature ovarian insufficiency

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

The following are not **covered services**:

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

Scalp hair prosthesis

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

Contraceptives

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

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

Types of claims and communicating our claim decisions

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

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

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

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

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

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

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

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

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

Amendment: Delaware Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and **ambulance** assistance. If possible, call your **physician** but only if a delay will not harm your health.

Emergency department HIV screening

Eligible health services include the cost of one annual voluntary HIV screening tests performed while receiving **emergency services**, other than HIV screening, in a **hospital** emergency room. The cost associated with administering the HIV screening tests will include:

- Laboratory expenses to analyze the test
- Communicating to the patient the results of the test
- Any follow-up instructions for obtaining health care and supportive services

Coverage is not subject to any annual or **coinsurance** deductible or any **copayment** other than the **co-payment** that the insured would have to pay for the applicable hospital emergency department visit.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *exception- Emergency services and urgent care and Precertification covered benefit reduction* sections for specific plan details.

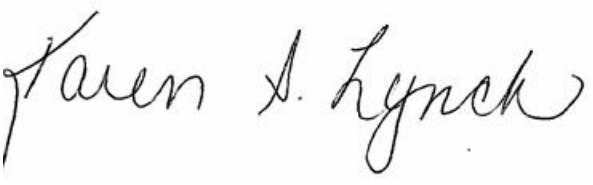
Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training and education
  - Self-management training and education provided by a health care **provider** certified in diabetes self-management training and education

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

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



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

Amendment: District of Columbia Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

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

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

- Your spouse
- Your domestic partner.
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Your legally adopted children
    - Your foster children, including any children placed with you for adoption
    - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)
    - Your grandchildren in your court-ordered custody
    - A grandchild when his/her parent is already covered as a dependent under this plan
    - Any other child with whom you have a parent-child relationship

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, you will be responsible for any additional premium charges due effective from the date of birth.
- A newborn child of a covered dependent other than your spouse is covered for 18 months. At the end of 18 months coverage the newborn will be terminated. You must enroll the newborn within 60 days of the date of birth
- An adopted child - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days from the moment of placement in your residence. In the case of an adopted newborn child, the child is covered for the first 31 days from the moment of birth
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, you will be responsible for any additional premium charges due effective from the date of adoption.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other group health plan of any covered dependent

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk human papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- Child Health Supervision Services for children from birth through age 16, including a physical examination, developmental assessment; anticipatory guidance, appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.
- For covered newborns, an initial **hospital** checkup.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

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

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

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a

network OB, GYN or OB/GYN.

Autism spectrum disorder

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

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

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

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

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

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

Birthing center

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

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery
- Services rendered by a certified nurse midwife, licensed midwife or birthing center in connection with childbirth

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Jaw joint disorder treatment

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

Cleft lip and palate

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

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

Maternity and related newborn care

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

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

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

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Eligible health services for reconstructive breast surgery includes:

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

Mastectomy Reconstruction And Prosthetic Expense

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

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

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

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).
Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, speech therapy and applied behavior analysis

Eligible health services include:

- Physical therapy, (except for services provided in an educational or training setting) if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.
  (Speech function is the ability to express thoughts, speak words and form sentences).

Dermatological Services

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

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

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

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

Why would we end you and your dependents coverage?

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

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

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

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the date you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group policy terminates or at the end of the period defined by the policyholder following the date on which you no longer meet the eligibility requirements.

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

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

Amendment: Florida Medical ET
Issue Date: January 4, 2021

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

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Well woman preventive visits

Eligible health services include your routine:

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

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms - including baseline
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- CA-125 serum tumor marker testing; transvaginal ultrasound; and rectovaginal pelvic exam for women age 35 and over who are at risk of ovarian cancer
- Lung cancer screenings

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

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

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

Hospital and other facility care

Hospital care

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital.**
- Operating and recovery rooms.
- Intensive or special care units of a **hospital.**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital.**
- Anesthesia and hospital charges for dental care, if:
  - You are 7 years old or younger or are developmentally disabled.
  - A successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition.
  - You have sustained extensive facial or dental trauma, unless otherwise covered by worker's compensation.

Autism spectrum disorder

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

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

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

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

- Physical therapy
- Occupational therapy
- Speech therapy

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

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

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

Jaw joint disorder treatment

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

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

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

Amendment: Georgia Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 60 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 60 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan.
  - We must receive your completed enrollment information not more than 60 days after the date you file a Declaration of Domestic Partnership, or not later than 60 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either
    - On the date your Declaration of Domestic Partnership is filed or
    - The first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 60 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium contribution** for the covered dependent.
  - If additional **premium contribution** is required to enroll the child, you will have at least 31 days from the date you receive the bill to make the required payment. If you miss this deadline, your newborn will not have health benefits after the first 60 days.

- An adopted child - A child that you, or that you and your spouse or domestic partner adopts, or a child that is **placed for adoption** with you, is covered on your plan for the first 60 days after the date of birth. If the child is **placed for adoption** more than 60 days after the date of birth, they are covered for 60 days from the date of placement.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days of birth or placement.
  - You must still enroll the child within 60 days of birth or placement even when coverage does not require payment of an additional **premium contribution** for the covered dependent.
  - If additional **premium contribution** is required to enroll the child, you will have at least 31 days from the date you receive the bill to make the required payment. If you miss this deadline, your adopted child will not have health benefits after the first 60 days.
  - If a child **placed for adoption** with you is removed from placement prior to being legally adopted, coverage for that child will end.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 60 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It will be either:
    - On the date of your marriage or the date your Declaration of Domestic Partnership is filed or
    - The first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Routine cancer screenings (applies whether performed at a physician or PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • As required by state law where stricter. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration; or • As required by state law where stricter. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Mammogram maximums	Mammograms are covered for any woman who wants one, if there is a medical reason. You are covered for at least the number of mammograms listed below, depending on your age.* • Women age 35 through 39 - One baseline mammogram • Women age 40 through 49 - One mammogram every two years, unless your **physician** recommends a mammogram more often • Women age 50 and older - One mammogram every year	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any mammogram or lung cancer screenings that exceed the mammogram or lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

Autism spectrum disorder

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

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

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

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

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

Any voluntary termination of pregnancy coverage that may be provided by the plan has been removed from the Booklet-Certificate, unless the procedure is necessary to preserve the life of the mother.

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

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

Amendment: Idaho Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

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

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

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

Preventive care immunizations

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

- Adults:
  - Herpes Zoster
  - Mumps
  - Rubella
  - Shingles if you are 60 years of age or over.

- Adults and children from birth to age 18:
  - Diphtheria
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus (HPV)

- Influenza (flu shot)
- Measles
- Meningococcal
- Pertussis (whooping cough)
- Pneumococcal
- Tetanus
- Varicella (Chickenpox)

- Children from birth to age 18:
  - Haemophilius influenza type b
  - Inactive poliovirus
  - Rotavirus.

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

Well woman preventive visits

Eligible health services include your routine:

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

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

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

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

The following has been added to or replaced in the *Specific Therapies and Tests* section of your booklet-certificate.

Diagnostic complex imaging, x-ray and other radiological services

Covered services also include a **medically necessary** diagnostic mammogram. No additional expense, such as a **copay** or **deductible**, will be imposed for mammograms.

Maternity and related newborn care

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

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

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

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, physical complications of all stages of the mastectomy, including lymphedema and prostheses. It also includes a **physician** office visit or in home nurse visit within 48 hours after discharge.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Court-ordered treatment of substance abuse disorders

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

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

Claim procedures

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the policyholder. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any medical documentation you received from your provider
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible.

Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid within 30 days after the necessary proof to support the claim is received. • If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.

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

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

Amendment: Illinois Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Adding new dependents

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

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

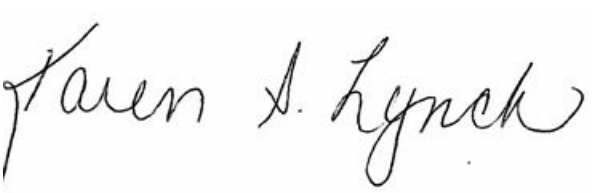
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 60 days.
- An adopted child - A child that you, or that you and your spouse, civil union partner or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 60 days.
- A stepchild - You may put a child of your spouse, civil union partner or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

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



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

Amendment: Iowa Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - You must enroll the child within 31 days of birth when coverage requires payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
  - If your coverage type is employee and dependents or family, your newborn is automatically covered from the date of birth. We encourage you to complete and submit an enrollment form for your newborn child.

- An adopted child - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - You must enroll the child within 31 days of placement for adoption when coverage requires payment of an additional premium for the covered dependent.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
  - If your coverage type is employee and dependents or family, your adopted child is automatically covered from the date of placement. We encourage you to complete and submit an enrollment form for your adopted child.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other group health plan of any covered dependent

Well woman preventive visits

Eligible health services include your routine:

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

If you need a routine gynecological exam, you may go directly to a network OB, GYN or OB/GYN.

Well woman preventive visits routine gynecological exams (including pap smears)			
Performed at a **physician's**, obstetrician (OB), gynecologist (GYN), OB/GYN office, or a mobile unit	100% per visit No **deductible** applies	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Maximums	With the exception of pap smears, these benefits are subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	With the exception of pap smears, these benefits are subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	With the exception of pap smears, these benefits are subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

These benefits with the exception of mammograms will be subject to any age, family history and frequency guidelines that are:

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

If you need a routine gynecological exam, you may go directly to an OB, GYN or OB/GYN.

Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Routine cancer screenings	100% per visit No **deductible** applies	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Maximums	With the exception of mammograms, these benefits are subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	With the exception of mammograms, these benefits are subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	With the exception of mammograms, these benefits are subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*	1 screening every 12 months*
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.			

Telemedicine

Telemedicine services given by **providers** that are not contracted with Aetna as **telemedicine providers** are **eligible health services**.

Anesthesia and hospital charges for dental care

Eligible health services include anesthesia for dental care only if you:

- Have a disability or condition that requires a dental procedure be done in a **hospital** or outpatient surgery center
- Are severely disabled
- Are in poor health and have a medical need for general anesthesia
- Are under 5 years old

Autism spectrum disorder

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

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

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

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

Autism spectrum disorder			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis or autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Important note: There are no visit limits for autism physical, speech and occupational therapies			

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, including a child you adopt within ninety (90) days of birth, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the delivery and obstetrical services for the birth mother of a child you adopt within ninety (90) days of birth.

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

Any voluntary termination of pregnancy coverage that may be provided by the plan has been removed from the Booklet-Certificate, unless the procedure is necessary to preserve the life of the mother.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or **terminal illnesses** and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- The treating **physician** determines based on published, peer-reviewed scientific evidence that you may benefit from the treatment.
- If you have been diagnosed with cancer, you have been accepted into a phase I, phase II, phase III or phase IV clinical trial for cancer.

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

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services

    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Osteoporosis

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

You pay no more for orally administered cancer medications than for the same covered intravenously or injected cancer medication.

Off-label use

U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

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

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Off-label use

Eligible health services include drugs for the treatment of cancer.

Psychotherapeutic drugs
Eligible health services include psychotherapeutic drugs for mental illness which are covered equally favorable as coverage for other prescription drugs.

How can you extend coverage when getting inpatient care when coverage ends?
Your coverage may be extended if you or your dependents are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

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

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

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

How can you obtain other coverage after your group coverage ends?
When your group health plan ends, you and your dependents may be eligible to apply for comprehensive guaranteed issue coverage through an individual policy inside or outside the Health Insurance Marketplace:

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

Application and payment of the initial premium for such individual policy should be consistent with the terms described in the respective policy chosen by you. Call the toll-free number on your ID card to learn about other insurance coverage options available to you.

Any *When you are injured* subsection that may appear in the *A bit of this and that -- Some other money issues* section no longer applies.

Work related illness or injuries

- Benefits will not be provided for services, **injuries** or diseases related to your job to the extent you are covered or are required to be covered by Workers' Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation law, the policy will not pay those medical benefits that would have been payable in absence of that settlement.

The definition of a **physician** also includes an Advanced Practice Registered Nurse (APRN).
This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

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

Amendment: Kansas Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

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

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

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

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

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Well woman preventive visits

Eligible health services include your routine:

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

Well woman preventive visits routine gynecological exams (including annual pap smears)			
Performed at a **physician's**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

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

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

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

Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Mammograms Baseline mammogram (one baseline mammogram, for a female age 35 but less than age 40; one mammogram every 12-24 months or more frequently if recommended by the person's physician, for a female age 40 but less than age 50; and one mammogram every 12 months for a female age 50 or over)	100% per visit No **deductible** applies.	50% (of the **recognized charge**) per visit No **deductible** applies	100% per visit No **deductible** applies.
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

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

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

Sigmoidoscopies	100% per visit No **deductible** applies.	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies.
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

Fecal Immunochemical Test for blood (FIT)	100% per visit No **deductible** applies.	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies.
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. • Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. • Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. • Current recommendations established by the American College of Gastroenterology (ACOG) in consultation with the American Cancer Society. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

Other routine cancer screening	100% per visit No **deductible** applies.	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies.
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*	1 screening every 12 months*
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.			

Anesthesia for certain dental procedures

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

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

Anesthesia for certain dental procedures does not include services:

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

Autism spectrum disorder

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

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

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

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

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

Cleft lip and cleft palate

Eligible health services include services and supplies for:

- Oral and facial surgery, including care by a **physician** before and after surgery
- Oral prosthesis
- Installation of dentures
- Replacement of dentures, fixed bridgework, or fixed partial dentures because of growth, resulting in structural changes in the mouth or jaw
- Cleft orthodontic therapy
- Orthodontic, otolaryngology or prosthetic treatment and management
- Installation of crowns
- Diagnostic **physician** services to find out the extent of loss in your ability to speak or hear
- Speech therapy by a **physician** to overcome congenital or early acquired disabilities

- Rehabilitative speech therapy (including speech aids and training) by a **physician** to restore or improve your ability to speak
- Psychological assessment and counseling
- Genetic assessment and counseling for your dependent child and both parents
- Hearing aids
- Hearing loss assessment, treatment and management, including surgically implanted amplification devices
- Physical therapy assessment and treatment
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy

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

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

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

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

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

Eligible health services include:

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

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

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

Maternity and related newborn care

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

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

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

Pregnancy complications

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

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

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

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

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

Jaw joint disorder treatment

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

Jaw joint disorder treatment			
Jaw joint disorder treatment	60% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit	60% (of the **recognized charge**) per visit

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**.
  - **Intensive Outpatient Program** provided in a facility or program for mental health treatment provided under the direction of a **physician.**
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor.

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

Ambulance service

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

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

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

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

For purposes of this benefit:

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

Clinical trial therapies (experimental or investigational)

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

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

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

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an institutional review board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

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

1. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention of early detection of cancer
2. The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV, clinical trial for cancer
3. The treatment is being provided in accordance with an approved clinical trial must satisfy one of the following:
    - Federally funded trials:
        - The study or investigation is approved or funded by one or more of the following:
            - The National Institutes of Health
            - The Centers for Disease Control and Prevention
            - The Agency for Health Care Research and Quality
            - The Centers for Medicare & Medicaid Services
            - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
            - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
            - The Department of Veterans Affairs
            - The Department of Defense
            - The Department of Energy

- For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Hearing aids and exams for adults

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

Hearing aid means:

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

Hearing aid services are:

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

Hearing aids and exams for minors

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

Hearing aid means:

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

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
    - A **physician** certified as an otolaryngologist or otologist
    - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist

- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

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

Nutritional supplements

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

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

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

Osteoporosis

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

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

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

Prosthetic devices and services

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

Prosthetic device means:

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

Coverage includes:

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

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

Translation charges

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

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

Retail pharmacy

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

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

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

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

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

Orally administered anti-cancer drugs, including chemotherapy drugs
Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

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

Keeping a provider you go to now (continuity of care)
You may have to find a new **provider** when:

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

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

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

If you are pregnant and have entered your second trimester, or are diagnosed to have a high-risk pregnancy, the transitional period will include the time required for postpartum care directly related to the delivery.

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

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

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

When you are injured

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

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

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

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

Coordination of benefits

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

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

Key Terms

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

Allowable expense means:

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

Claim determination period or plan year:

- A period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefit payable in the absence of COB to determine whether over-insurance exists and how much each plan will pay or provide.
  - The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group or individual contact. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

- As each claim is submitted, each plan determinations its responsibility and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination.

Closed panel plans(s) means

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

Custodial parent means:

- The parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

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

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

A plan does not include:

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

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

How COB works

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

Determining who pays

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

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

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

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan:
  - Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.
  - Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by contractholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- Each plan determines its order of benefits using the first of the following rules that apply:

If you are covered as a:	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an **employee**, retired **employee** or subscriber (not as a dependent)	Plan covering you as a dependent
Exception to the rule above when you are a Medicare beneficiary	If you or your spouse is a Medicare beneficiary: • And as a result of federal law, Medicare is secondary to the plan covering you or your spouse as a dependent • And primary to the plan covering the person as other than a dependent (e.g. a retired **employee**) • Then the order of benefits between the two plans is reversed so that the plan covering the person as an **employee** or retired **employee** is the secondary plan and the other plan is the primary If you have any questions about this you can contact us: • See the section How COB works with Medicare below. • Online: Log on to your secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans. • By phone: Call the toll-free number on your ID card.	Same rule under Primary plan

If you are covered as a:	Primary Plan	Secondary plan
Child of: • Parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule*) *Same birthdays – the plan that has covered a parent longer is primary	Plan of parent whose birthday* is later in the year *Same birthdays – the plan that has covered a parent longer is primary
Child of: • Parents separated, divorced, or not living together, whether or not they have been married and the plan of that parent has actual knowledge of the terms, that plan is primary • With court-order will apply to plan years beginning after the plan is given notice or the court-order	• Plan of parent responsible for health coverage in the court order • If that parent has no coverage then their spouse's plan is primary	• Plan of other parent • If the parent has no coverage then their spouse's plan is primary
Child of: • Parents separated, divorced, or not living together, whether or not they have been married court-order states both parents are responsible for coverage or have joint custody where the court did not state that one parent is responsible for health coverage	Primary coverage is based on the birthday rule	Secondary coverage is based on the birthday rule
Child of: • Parents separated, divorced, or not living together, whether or not they have been married and there is no court-order that states which parent is responsible for health coverage	The order of benefits payment is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	See rule as Primary plan

If you are covered as a:	Primary Plan	Secondary plan
Child covered under: • More than one plan by an individuals who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See all "Child of" content above	Same rule as Primary plan
Child covered by the spouse's plan: • When the child has health coverage under either or both parents' plans and also has health coverage a dependent under the spouse's plan	See "Longer or shorter length of coverage" Shown below	Same rule as Primary plan
Child covered by the spouse's plan: • In the event the child's health coverage under the spouse's plan began on the same date as the health coverage under either or both parents' plan	Primary and secondary coverage is based on the birthday rule of the child's parent or spouse See "Child of" content above	Same rule as Primary plan
Active or inactive **employee**	Plan covering you as an active **employee** (or dependent of an active **employee**)	Plan covering you as a laid off or retired **employee** (or dependent of a former **employee**)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an **employee** or retiree (or dependent of an **employee** or retiree) is primary to COBRA or under a state or other Federal continuation of coverage If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applies	COBRA or state or other Federal continuation coverage If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applies
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	If none of the above rules apply, the plans share the allowable expenses equally between the plans meeting the definition of "plan" shown in the "key terms" above This plan will not pay more than it would had it been the primary plan	If the other plan does not have this rule, as a result, the plans do not agree on the order of benefits, this rule is not applies~~s~~d This plan will not pay more than it would had it been the primary plan

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved
Secondary plan	Effect of the benefits when the plan is secondary: • It may reduce its benefits so that the plans during a year are not more than the total allowable expenses • In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan • May then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim • Shall credit to its plan **deductible**, **coinsurance**, **copayments** and any amount it would have credited to its **deductible** in the absence of other health care coverage • It may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100% of total allowable expenses
Benefit reserve*	The benefit reserve when this plan is the secondary plan: • Is the difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person an used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period • As each claim is submitted will determine: – Its responsibility to pay or provide benefits under its contract – Whether a benefit reserve has been recorded for the covered person – Whether there are any unpaid allowable expenses during that claims determination period • Will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim

	determination period • At the end of the claims determination period, the benefit reserve returns to zero • A new benefit reserve must be created for each new claim determination period

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

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

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

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

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

How COB works with Medicare

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

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

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

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The **employer** has 20 or more **employees**	Your plan	Medicare
You are retired	Medicare	Your plan

If you have Medicare because of:

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

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

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate our benefits as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expenses.

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

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current plan must be offered through the policyholder.

Other health coverage updates – contact information

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

Right to receive and release needed information

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

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

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

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

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

Right to pay another carrier

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

Right of recovery

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

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

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

Summary of Coordination of benefits procedures

IMPORTANT NOTICE

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

Double coverage

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

Primary or secondary?

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

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

When this plan is primary

If you or a family member are covered under another plan in addition to this one, we will be primary. When we will be primary, see the chart under "Determining who pays" for:

- Your own expenses
- Your spouse's expenses
- Your child's expenses

Other situations

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

How we pay claims when we are primary

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

How we pay claims when we are secondary
We will be secondary whenever the rules do not require us to be primary.

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

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

Questions about Coordination of Benefits?
Contact your state insurance department

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Types of claims and communicating our claim decisions

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

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

Urgent care claim

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

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

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

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

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

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	2 days	30 days	As soon as possible but not later than 24 hours for urgent request*, or 72 hours if clinical information is required and received more than 24 hours after request 15 calendar days for non-urgent request

Extensions	None	15 days from the date of the pre-service claim request	15 days from the date of the post-service claim request	Not applicable
Additional information request (us)	As soon as possible but not more than 24 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

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

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

(a) We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized charge** with an **out-of-network provider,** except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all.

(a) A review that denies, reduces, terminates, or fails to provide or make a payment in full or in part, for the benefit based on a determination by us or its review organization of the covered person's eligibility to participate in our health benefit plan.

(b) Any pre-service review or post-service review that denies, reduces, or terminates, or fails to provide or make payment, in whole or in part, for a benefit under the health benefit plan.

(c) A rescission of coverage determination. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

(d) External reviews shall apply only to adverse benefit determinations and final adverse benefit determinations that involve:

- Medical judgment
- Appropriateness of a covered benefit
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- A service, supply, or treatment is experimental or investigational
- Rescission

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

Authorized representative

(a) A person to whom you have given express written consent to represent you. It may also include the your treating **provider** if you appoint the **provider** as your authorized representative and the **provider** waives in writing any right to payment from you other than any applicable **copayment** or other **coinsurance** amount. In the event that the service is determined not to be **medically necessary**, and you or your authorized representatives, except for the your treating **health professional**, thereafter requests the services, nothing shall prohibit the **provider** from charging usual and customary charges for all non-medically necessary services provided.

(b) A person authorized by law to provide substituted consent for you.

(c) Your immediate family member or your treating **health professional** when you are unable to provide consent.

(d) In the case of an urgent care request, a **health professional** with knowledge of your medical condition.

Grievance

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

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

The difference between a complaint and an appeal

A complaint

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

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

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

Exhaustion of appeals process

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

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

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

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

External review

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

The types of External reviews are:

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

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

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

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

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

To **Aetna**

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

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

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

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

Aetna will:

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

The IRO will:

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

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

How long will it take to get an IRO decision?

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

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

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

For initial adverse determinations

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

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

For final adverse determinations

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

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

Timeframes for external review decisions

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

Type of external review	When we complete a preliminary review of the request and notify you	When the review request is assigned to the IRO	When the IRO completes their review and notifies you
Standard external review	Within 5 business days	Within 1 business day after receiving request from **Aetna**	Within 45 days after the date of receipt of the request
Expedited external review (oral or written)	Immediately after receiving request	Immediately after receiving request from **Aetna**	As soon as possible but no longer than 72 hours after getting assigned
Standard external review of experimental or investigational treatment adverse determinations	• Within 5 business days after receiving request to determine eligibility	Within 1 business day after the date of receiving request from **Aetna**	Within 20 days after the date it receives the opinion of each clinical peer to make a decision (clinical peers have 20 days to provide a written opinion to IRO)

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

Recordkeeping

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

Fees and expenses

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

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

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

Amendment: Louisiana ET Rider
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

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

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

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

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

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

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

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

Children's health supervision

Eligible health services include child health supervision services.

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

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

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

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

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

Hospital and other facility care

Hospital care

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.

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

Home health care

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

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

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

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

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

Autism spectrum disorder

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

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

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

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

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

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

- Developmental skills
- Functional behavior
- Needs
- Capacities

Treatment also includes, but is not limited to:

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

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

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

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

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

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

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

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

Clinical trial therapies (experimental or investigational)

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

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

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

Clinical trials (routine patient costs)

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

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

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

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

Diabetic equipment, supplies and education

Eligible health services include:

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

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

Jaw joint disorder treatment

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

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

Lyme disease

Eligible health services include treatment of Lyme disease.

Pediatric streptococcal related conditions

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

Port-wine stains

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

Mental health treatment

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

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

- **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
    - You are homebound
    - You **physician** orders them
    - The services take the place of a stay in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
    - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23-hour observation
- Peer counseling support by a peer support **specialist**
    - A peer support **specialist** serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

- **Residential treatment facility**, licensed by the Commissioner of Human Services, for the treatment of emotionally disabled children. "Emotionally disabled child" has the meaning set forth by the Commissioner of Human Services in the rules relating to **residential treatment facilities**.
- Court-ordered **mental disorders** services to treat or improve an emotional, behavioral or psychiatric condition, otherwise covered under this **group policy**. The court order must be issued based on a behavioral care evaluation performed by a licensed **psychiatrist** or a doctoral level licensed psychologist. The court order and behavioral care evaluation must:
    - Be provided to **Aetna**
    - Include a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

Eligible health services include the:

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

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

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

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a **medically necessary** (as determined in consultation between you and your **physician**) mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** when incidental to or follows a **surgery** resulting from **injury**, **illness** or other diseases of the involved part.
- Your covered dependent child's **surgery** due to a congenital disease or anomaly which resulted in a functional defect, as determined by their **physician**.

Durable medical equipment (DME)

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

Coverage includes:

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

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

For more information on **precertification**, including the criteria used in making decisions and limitations pertaining to **DME**, call the toll-free Member Services number on your member ID card or log on to your secure website at www.aetna.com.

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

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

Hearing aid means:

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

Hearing aid services are:

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

For individuals 18 years of age or younger:

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

Nutritional supplements

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

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

Prosthetic devices

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

Prosthetic device means:

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

Coverage includes:

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

Non-preferred drug guide antipsychotic prescription drugs

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

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

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

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

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

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

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

In order to be eligible for continuity of care:

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

The continuing care benefit will be extended annually when:

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

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

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

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

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

How do I request a medical exception?

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for which health care services are denied through **precertification** or **step therapy**. You, someone who represents you or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the **preferred** or **non-preferred drug** benefit level.

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

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

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

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

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

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

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

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

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

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

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

	If you are a new enrollee and your provider is an out-of-network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your **provider** should call **us** for approval to continue any care.
Length of transitional period	Care will continue during a transitional, for up to 120 days.	Care will continue during a transitional period for up to 120 days. This date is based on the date the **provider** terminated their participation with **us**.

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

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

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

Important note--unauthorized provider services-surprise billing

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

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

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

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

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

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

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

Claim procedures

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

Types of claims and communicating our claim decisions

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

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

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

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

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

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

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

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

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

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

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

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

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

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the last day of the month in which you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group policy terminates or at the end of the month of the period defined by the policyholder following the date on which you no longer meet the eligibility requirements.

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

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

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

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

You may extend coverage until the earliest of:

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

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

Your dependents can continue coverage after your death if:

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

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

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

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

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

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

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

- Payment is made for the coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The end of the 36 month period after you enroll in Medicare
- They no longer meet the definition of dependent

- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop
- The date your spouse remarries

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

When you are injured

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

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

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

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

Jaw joint disorder

This is:

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

Medically necessary/medical necessity

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

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

Medically necessary/medical necessity (mental health)

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, level, setting and duration, and considered effective for your **illness**, **injury** or disease

Generally accepted standards of medical practice parameters are:

- Consistent with the standards in the same or similar general specialty that typically manage the condition, procedure or treatment and must:
  - Help restore or maintain your health
  - Prevent deterioration of your condition

Telemedicine

A consultation between you and a **provider** performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls, except for behavioral health services
- Any other method required by state law

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

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

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

Amendment: Minnesota Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days from the earlier of the date of placement or the date an order is entered to grant the adoptive parent custody.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms, including one baseline mammogram for a woman between age 35 and 40, one mammogram every two years for a woman between age 40 and 49, and one mammogram every year for women 50 and older
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

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

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

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

Preventive care immunizations			
Performed in a facility or at a **physician's** office No deductible applies to immunizations for dependent children to age 6.	100% per visit No **deductible** applies	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card.

Autism spectrum disorder

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

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

We will cover early intensive behavioral interventions such as Applied Behavior Analysis. Applied Behavior Analysis is a process that evaluates environmental changes and uses behavioral stimuli and consequences to improve social behavior. To do this, Applied Behavioral Analysis uses techniques like:

- Direct observation
- Measurement
- Functional analysis of the relationship between environment and behavior.

The goal of this process is to:

- Systematically change behavior, and
- Achieve observable improvements in behavior.

Autism spectrum disorder			
Autism spectrum disorder treatment Covered for children age 0-21	Covered according to the type of benefit.	Covered according to the type of benefit.	Covered according to the type of benefit.
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum per week for Behavioral Health Services and Applied Behavioral Analysis	25* hours per week	25* hours per week	25* hours per week
*Payments provided by Aetna for treatment other than Behavioral Health Services including Applied Behavioral Health Services cannot be applied to the maximum benefit. Benefits are subject to the same cost share as any other illness covered under the plan. Benefits for the treatment of Autism Spectrum Disorder are not subject to any visit limits except for Behavioral Health Services which includes Applied Behavior Analysis			

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Alcohol swabs
  - Medication including insulin
  - Insulin infusion devices
  - Glucagon agents and emergency kits
  - Test strips for glucose monitoring and/or visual reading
  - Urine testing strips
  - Podiatric appliances
- Equipment
  - External insulin pumps and all other insulin pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training
  - Home visits when medically necessary and prescribed by a health care professional

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

Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Orally administered anti-cancer drugs, including chemotherapy drugs, and drugs to treat human immunodeficiency virus or acquired immunodeficiency syndrome

Eligible health services include any drug prescribed for the treatment of cancer, human immunodeficiency virus or acquired immunodeficiency syndrome if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your **network pharmacy** can coordinate that for you. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription drugs.**

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Types of claims and communicating our claim decisions

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

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

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

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

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

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

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

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

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

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

Adverse benefit determinations
We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

You may receive an "adverse benefit determination" if;

- We determine you or your dependent is not eligible for coverage under this plan.
- A utilization review decision is made that care does not satisfy criteria such as:
  - Appropriateness of a **covered benefit**
  - Health care setting
  - Level of care
- A service, supply, or treatment is **experimental or investigational**
- The care is not **medically necessary** or appropriate

- We rescind your coverage

Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

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

The difference between a complaint and an appeal

A complaint

You may not be happy about:

- A **provider**
- An operational issue
- Claims payment, handling or reimbursement
- Any matter except an adverse benefit determination

You can call or write Member Services. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 15 business days of receiving the complaint**.** We will let you know if we need more information to make a decision. We may take an additional 15 working days to issue our written decision.

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. If our decision is not in favor of paying your claim, this decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 business days	15 business days	As appropriate to type of claim

Exhaustion of appeals process

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

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

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

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

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

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an independent review organization (IRO).Adverse benefit determinations and final adverse benefit determinations are eligible for IRO review.

You have a right to external review only if:

- Our claim decision involved medical judgment.
- We decided the service or supply is not **medically necessary** or not appropriate.

- We decided the service or supply is **experimental or investigational**.
- You have received an adverse determination or determination.

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

You must submit the Request for external review form:

- To the Nebraska Department of Insurance
- Within four months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

Nebraska will:

- Contact the IRO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.

The IRO will:

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

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

How long will it take to get an IRO decision?

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

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

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

For initial adverse determinations

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

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

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

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

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

Recordkeeping

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

Fees and expenses

We will pay for the cost of the IRO, but we do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

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

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

Amendment: Nebraska Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

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

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

Pre-Service Claim Determinations

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

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

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

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

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

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

Amendment: New York Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Preventive care immunizations			
Performed in a facility or at a **physician's** office No **deductible** applies to childhood immunizations	100% per visit No **deductible** applies	50% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms, including:
  - two and three-dimensional
  - women under age 40 when recommended by a **physician**
  - annually for women age 40 and older
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Cytology tests
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Any combination of colorectal cancer screening tests when prescribed by your **physician**. If you are at high risk for colorectal cancer and under the age of 50, you may be eligible for any combination of colorectal cancer tests based on the American Cancer Society guidelines.
- Lung cancer screenings

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

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

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

Nutritional supplements

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

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving, made of 100% free amino acids as the protein source, and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

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

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

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

Amendment: Pennsylvania Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
  - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child/child placed for adoption - A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after the adoption is complete or from the date of placement for adoption, which means you have taken on legal obligation for total or partial support of the child.

- To keep your adopted child/child placed for adoption covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- If you miss this deadline, your adopted child/child placed for adoption will not have health benefits after the first 31 days.

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status
It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

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

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

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

Hospital and other facility care

Hospital care

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**
- Operating and recovery rooms

- Intensive or special care units of a **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital.**
- For mastectomy, 48 hour of inpatient care in a network hospital. In case of early discharge, one home visit if ordered by your attending physician.

Autism spectrum disorder

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

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

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

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

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

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

Cleft lip and cleft palate

Eligible health services include treatment of cleft lip and palate and any related condition or illness. This includes but not limited to:

- Oral and facial surgery, surgical management and follow up care

- Prosthetic treatment such as obdurators, speech appliances and feeding appliances
- Orthodontic and prosthodontic treatment and management
- Otolaryngology treatment and management
- Audiological assessment, treatment and management, including surgically implanted amplification devices
- Physical therapy assessment and treatment

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

Maternity and related newborn care

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

- Without precertification, 48 hours of inpatient care in a **hospital** after a vaginal delivery, not including the day of the delivery
- Without precertification, 96 hours of inpatient care in a **hospital** after a cesarean delivery, not including the day of the delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

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

Reconstructive surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, physical complications of all stages of the mastectomy, including lymphedema, and prostheses. We will also cover breast prosthesis devices after a mastectomy.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Continuation of coverage under South Carolina law

You may continue coverage for the remaining of the month in which your coverage ended plus an additional 6 months if:

- You have been continuously covered under this policy for at least 6 months before it was ended
- The policy was ended due to any reason other than nonpayment of the premium, and
- Your are not eligible for:
    - Other group coverage that provides similar benefits
    - Medicare benefits
    - COBRA

Upon termination, the policyholder will notify you of your right to continue coverage and the amount of your premium. You need to send the application within 30 days after the qualifying event.

Continuation of coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You fail to make the necessary payments on time.
- You become covered under another group health plan that provides similar benefits.

You become entitled to benefits under Medicare.

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

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

Amendment: South Carolina Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Adding new dependents

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

- A spouse - if you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your employer when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your employer
  - Ask your employer when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child - A child that you, or that you and your spouse or domestic partner, adopts is covered on your plan beginning from the:
  - Moment of birth, if placement for adoption occurs within 31 days of the child's birth
  - Date of placement, if placement for adoption occurs after 31 days of the child's birth

  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the placement
  - If you miss this deadline, your adopted child will not have benefits after the first 31 days
  - See the *Eligible health services under your plan-Maternity and related newborn care* for information on the Adoption benefit
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask your employer when benefits for your stepchild will begin. It will be either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status
It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Autism spectrum disorder

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

Eligible health services are the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder, including:

- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care and
- Therapeutic care services provided by licensed or certified speech therapists, occupational therapists, or physical therapists

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

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

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

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

Autism spectrum disorder			
Autism spectrum disorder	Covered according to the type of benefit.	Covered according to the type of benefit.	Covered according to the type of benefit.
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is rendered.	Covered according to the type of benefit and the place where the service is rendered.	Covered according to the type of benefit and the place where the service is rendered.
Applied Behavior Analysis	Covered according to the type of benefit and the place where the service is rendered.	Covered according to the type of benefit and the place where the service is rendered.	Covered according to the type of benefit and the place where the service is rendered.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is rendered.	Covered according to the type of benefit and the place where the service is rendered.	Covered according to the type of benefit and the place where the service is rendered.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males
- Termination of pregnancy by abortion, only if:
  - The life or health of the mother would be endangered if the fetus were carried to term, or
  - The pregnancy is the result of an act of rape or incest or
  - The fetus has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal.

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services, including a scheduled or non-emergency cesarean delivery. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

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

Adoption benefit

We provide an adoption benefit of up to $4,000. This benefit is subject to the following:

- The benefit covers any expenses related to the adoption subject to the same deductibles, copays, and coinsurance amounts that apply to maternity services, as listed in your schedule of benefits
- The adopted child must be placed with you for adoption within 90 days of birth
- The adopting parent(s) must submit copies of the placement papers to **Aetna**, and
- No documentation of expenses is required.

If both adoptive parents have maternity coverage provided by different insurers, we will coordinate payment with the other insurance plan. However, the total benefit will not exceed $4,000 combined under both plans.

If you adopt more than one child from the same birth, only one benefit applies.

We may seek reimbursement from you of any paid adoption benefit if:

- The postplacement evaluation disapproves the adoption placement; and
- A court rules the adoption may not be finalized because of an act or omission of an adoptive parent affects the child's health or safety.

The following language is revised in the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Court-ordered services and supplies

- This includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered benefit** under your plan.

The following language is revised in the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic equipment, supplies and education.* This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program.

The following provision is added to the *What your plan doesn't cover-some eligible health services exceptions-General Exclusions* section of your booklet-certificate:

Behavioral health treatment

Services for the following categories (or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):

- **Stay** in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
- Education service, special education service, remedial education service, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage. If your dependent loses eligibility because of the limiting age, coverage wil remain in effect through the end of the month.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare plan that we offer. However, dependent's coverage will end if your coverage ends under the Medicare plan

- Your dependent has exhausted his or her maximum benefit under your plan.

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We will give you 31 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *A bit of this and that - Honest mistakes and intentional deception* section for more information on rescissions.

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

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the last day of the month in which you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group policy terminates or at the end of the month of the period defined by the policyholder following the date on which you no longer meet the eligibility requirements.

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

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

Amendment: Utah Medical ET
Issue Date: January 4, 2021

Aetna Life Insurance Company

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - $500,000 for health benefit plans
  - $500,000 in disability income insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org, or contact:

Utah Life and Health Insurance Guaranty Assoc. 32 West 200 South, #150
Salt Lake City, UT 84101 (801) 320-9955

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: PrideStaff, Inc.

Group policy number: GP-805902

Amendment effective date: January 1, 2021

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

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

Domestic Partners

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

- Your domestic partner and their dependent children

Adding new dependents

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

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

Mammograms

Eligible health services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis)

Neurodevelopmental therapy

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

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

Home health care

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

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

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

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

Exclusions

Your plan does not cover the following under this section:

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

Hospice care

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

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

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

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

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

Exclusions

Your plan does not cover the following under this section:

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

Abortion

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

Acupuncture

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

Nutritional supplements

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

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

Exclusions

Your plan does not cover the following under this section:

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

Jaw joint disorder treatment

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

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

The following are not covered under this benefit:

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

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

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

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

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

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

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

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

Coordination of benefits

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

Key terms

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

Allowable expense means:

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

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

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors

- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

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

Determining who pays

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

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as a non-dependent	The plan covering you as a dependent
Exception to the rule above when you are eligible for Medicare	If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online:** Log on to your **Aetna** secure member website at www.aetna.com • **By phone:** Call the number on your ID card	
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays-the plan that has covered a parent longer is primary.	The plan of the parent born later in the year (month and day only).* *Same birthdays-the plan that has covered a parent longer is primary.
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.

Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See *Child of* content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.

Benefit reserve Each family member has a separate benefit reserve for each **calendar year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

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

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

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

- Age
- Disability
- End stage renal disease

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

Who pays first?

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

This plan is secondary to Medicare in all other circumstances.

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

Other health coverage updates – contact information

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

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

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

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

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

For claims involving **out-of-network providers:**

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

Types of claims and communicating our claim decisions

You or your **provider** is required to send us a claim in writing. If you or your dependent goes to a **network provider**, the **network provider** will file the claims. When you go to an **out-of-network provider**, you will have to file the claims. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

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

Urgent care claim

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

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

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

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

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

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	Within 48 hours or Within 1 business day for an emergency request	5 calendar days	30 calendar days	No later than 24 hours for urgent request* or 5 calendar days for non-urgent request
Request for Extension	Not applicable	Within 5 calendar days	15 calendar days	Not applicable
Additional information request (us)	24 hours	5 calendar days	30 calendar days	Not applicable
Response to receipt of additional information request (you)	48 hours	30 calendar days	45 calendar days	Not applicable

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

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** if you go to a **network provider** and the **recognized charge** if you go to an **out-of-network provider**, except for your share of the costs.

But sometimes we may pay only some of the claim. And sometimes we may deny payment or service entirely.

We may sometimes:

- Deny
- Change
- Reduce, or
- Terminate your
- Health care services or benefits
- Authorization relating to such services or benefits, or
- Coverage or payment for the health care services or benefits

Such actions are called "adverse benefit determinations." Other actions that are also called "adverse benefit determinations" include:

- We do not authorize a **stay** in a **hospital** or other facility
- We decide that you or your dependents were not eligible for the coverage when you received the services
- We decide that you have reached your benefit maximums
- Your health care services are excluded, not covered or limited in some way
- We rescind your coverage entirely

Reasons for adverse benefit determinations may be:

- The results of utilization review activities
- The health care services are **experimental or investigational**
- The health care services are not **medically necessary**

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

The difference between a grievance and an appeal

A grievance

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

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	24 hours, but no longer than 72 hours	14 days, or 20 days for an **experimental or investigational** treatment. We will let you know within 72 hours that we have received your appeal		As appropriate to type of claim
Extension to respond (us)	None	16 additional days, if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.		

Exhaustion of appeals process

In most situations you must complete the one level of appeal with us before you can pursue arbitration, litigation or other type of administrative proceeding.

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

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally. See the *How to contact us for help* section for details on how to reach us.

- We did not follow all of the claim determination and appeal requirements of Washington or of the Federal Department of Health and Human Services. You will not be able to proceed directly to external review if the violation was:
  - Minor and not likely to influence a decision or harm you
  - For a good cause or beyond our control
  - Part of an ongoing, good faith exchange between you and us

At any time you may contact the Washington Office of the Insurance Commissioner to request an investigation of a grievance or appeal.

External review

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

You have a right to external review if:

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

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 180 calendar days of the date you received the decision from us

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

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

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Will accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an ERO decision?
We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

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

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

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

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

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

Fees and expenses
We do not pay any fees or expenses incurred by you when you submit a grievance or appeal.

Out-of-network benefits disclosure
Your health plan's out-of-network benefits
Not all health coverage plans provide out-of-network benefits. Please refer to your schedule of benefits for a description of your health plan's out-of-network benefits.

Notice of consumer rights
Washington State has developed a notice of consumer rights. You can find this in your certificate of coverage.

Out-of-network costs
You may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on whether the provider, a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will pay for your
out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

"In network" means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network.

Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance, copayments, and deductible that applies. Your network doctor will handle any precertification your plan requires.

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

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

How to use the transparency tool

Aetna provides online tools to help you determine the cost of health care services and your potential share of those expenses. After logging in to our member website, you can search for procedures and providers to see estimated costs.

Search our network for doctors, hospitals and other health care providers

Use our online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by ZIP code or enter a specific doctor's name in the search field.

Visit **Aetna.com** and log in. From your secure member website home page, select "Find Care" from the menu bar and start your search.

Our online search tool is more than just a list of doctors' names and addresses. It also includes information about:

- Where the doctor went to medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Obtain an estimated range of the out-of-pocket costs for an out-of-network benefit

Contact member services at the number on your ID card for help estimating your out-of-pocket cost for an out-of-network benefit. Out-of-network providers do not have a contracted rate with Aetna. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. However, your out-of-pocket costs may be much higher compared to the costs of using a network provider. Your out-of-pocket costs for an out-of-network benefit, if included in your plan, consists of your out-of-network deductible plus your plan coinsurance. To estimate your coinsurance amount, subtract the remaining plan deductible from the provider's billed charge. Then multiply the balance by your coinsurance percentage.

Policies and plans are insured and/or administered by Aetna Life Insurance Company or its affiliates (Aetna).
Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to **Aetna.com** for more information about Aetna® plans.

Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted, or if the doctor or facility performs a different service at the time of your visit
This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

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

Amendment: Washington Medical ET
Issue Date: January 4, 2021