BENEFIT PLAN

Preferred Provider Organization (PPO) Medical Plan

Booklet-certificate

Prepared exclusively for:

Policyholder:	Pace University
Policyholder number:	GP-0181579
	Booklet-Certificate: 2
Group policy effective date:	January 1, 2022
Plan effective date:	January 1, 2022
Plan issue date:	February 28, 2022

Underwritten by Aetna Life Insurance Company

Welcome

Thank You for choosing Aetna.

This is Your Certificate of coverage. It is one of three documents that together describe the benefits covered by Your Aetna plan for in-Network and out-of-Network coverage.

This Certificate will tell You about Your Covered Benefits – what they are and how You get them. If You become insured, this Certificate becomes Your Certificate of coverage under the Group Policy, and it takes the place of

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Let's get started!

Here are some basics. First things first – some notes on how we Use words. Then we explain how Your plan works so You can get the most out of Your coverage. But for all the details – and this is very important – You need to read this entire Certificate and the Schedule of Benefits. And if You need help or more information, we tell You how to reach Us.

Some notes on how We Use words

When We say "You" and "Your", We mean both You and any covered dependents.
When We say "Us", "We", and "Our", We mean Aetna.
Some words appear in capitals. We define them in the *Glossary* section.

Sometimes We Use technical medical language that is familiar to medical Providers.

What Your plan does – providing Covered Benefits

Your plan provides Covered Benefits. These are Eligible Health Services for which Your plan has the obligation to pay.

This plan provides Participating and Non-Participating coverage for medical, vision and pharmacy insurance coverage.

How Your plan works – starting and stopping coverage

Your coverage under the plan has aplis p 5vs

2. **Providers**

Aetna's Network of doctors, Hospitals and other health care Providers are there to give You the care You need. You can find Participating Providers and see important information about them most easily on Our online Provider Directory. Just log into Your Aetna secure member Website at www.aetna.com.

You may choose a Primary Care Physician (We call that doctor Your PCP) to oversee Your care. Your PCP will provide Your routine care, and send You to other Providers when You need specialized care. You don't have to access care through Your PCP. You may go directly to Participating specialists and Providers for Eligible Health Services. Your plan often will pay a bigger share for Eligible Health Services that You get through Your PCP, so choose a PCP as soon as You can.

For more information about the Network and the role of Your PCP, see the *Who provides the care* section.

3. **Paying for Eligible Health Services– the general requirements**

There are several general requirements for the plan to pay any part of the expense for an Eligible Health Service. They are:

- The Eligible Health Service is Medically Necessary.
- You get the Eligible Health Service from a Participating or Non-Participating Provider.
- You or Your Provider Preauthorizes the Eligible Health Service when required.

You will find details on Medical Necessity and Preauthorization requirements in the *Medical Necessity and Preauthorization requirements* section.

4. **Paying for Eligible Health Services– sharing the expense**

Generally Your plan and You will share the expense of Your Eligible Health Services when You meet the general requirements for paying.

But sometimes Your plan will pay the entire expense; and sometimes You will. For more information see the *What the plan pays and what You pay* section, and see the Schedule of Benefits.

5. **Disagreements**

We know that people sometimes see things differently.

The plan tells You how We will work through Our differences. And if We still disagree, an independent group of experts called an "external review organization" or ERO for short, will make the final decision for Us.

For more information see the *When You disagree - Claim Determinations, Grievance and Appeals procedures* section.

How Your plan works while You are covered out-of-Network

The section above told You how Your plan works while You are covered in-Network. You also have coverage when You want to get Your care from Providers who are not part of the Aetna Network. It's called Non-Participating coverage.

Your Non-Participating coverage:

- Means You can get care from Providers who are not part of the Aetna Network.
- Means You will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to Us. You are responsible for completing and submitting claim forms for reimbursement of Eligible Health Services that You paid directly to a Provider.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for health care coverage.

When you can join the plan

As an employee You can enroll yourself and Your dependents:

- At the end of any waiting period the policyholder requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times You and Your dependents can join the plan* section below)

If You do not enroll yourself and Your dependents when You first qualify for health benefits, You may have to

Any unmarried dependent Child who is a full-time student and is on a medical leave from school due to illness. Coverage will continue for a period of twelve months from the last day of attendance at school. The Medical Necessity of a leave of absence from school must be certified by the student's attending physician who is licensed to practice in the state of New York. Written documentation of the illness must be submitted us.

- We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

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.

    - Shared rental payments of residence (need not be shared 50/50);
    - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
    - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
    - Shared household budget for purposes of receiving government benefits;
    - Status of one (1) as representative payee for the other's government benefits;
    - Joint ownership of major items of personal property (e.g., appliances, furniture);
    - Joint ownership of a motor vehicle;
    - Joint responsibility for child care (e.g., school documents, guardianship);
    - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
    - Execution of wills naming each other as executor and/or beneficiary;
    - Designation as beneficiary under the other's life insurance policy;
    - Designation as beneficiary under the other's retirement benefits account;
    - Mutual grant of durable power of attorney;
    - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
    - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
    - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.
- A newborn child - Your newborn child is covered on Your health plan for the first 31 days after birth.

  If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 31 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that

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

Medical Necessity and Preauthorization requirements

The starting point for Covered Benefits under Your plan is whether the services and supplies are eligible health services. See the *Eligible health services under Your plan* and *Exclusions* sections plus the Schedule of Benefits.

Your plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is Medically Necessary.
- You or Your Provider Preauthorizes the eligible health service when required.

This section addresses the Medical Necessity and Preauthorization requirements.

Medically Necessary; Medical Necessity

As We said in the *Let's get started!* section, Medical Necessity is a requirement for You to receive a Covered Benefit under this plan.

The Medical Necessity requirements are stated in the *Glossary* section, where We define "Medically Necessary, Medical Necessity." That is where We also explain what Our medical directors or their Physician designees consider when determining if an Eligible Health Service is Medically Necessary.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Preauthorization

You need pre-approval from Us for some Eligible Health Services. Pre-approval is also called Preauthorization.

In-Network

Your Physician is responsible for obtaining any necessary Preauthorization before You get the care. If Your Physician doesn't get a required Preauthorization, We won't pay the Provider who gives You the care. You won't

Preauthorization should be secured within the timeframes specified below. For Emergency Services, Preauthorization is not required, but you should notify us within the timeframes listed below. To obtain Preauthorization, call Us at the telephone number listed on Your ID card. This call must be made:

For non-emergency admissions:	You, Your Physician or the facility will need to call and request Preauthorization at least 14 days before the date You are scheduled to be admitted.
For an Emergency Medical Condition:	If possible, You or Your Physician should call prior to the outpatient care, treatment or procedure or as soon as reasonably possible.
For an Emergency Admission:	You, Your Physician or the facility must call within 48 hours or as soon as reasonably possible after You have been admitted.
For an Urgent Admission:	You, Your Physician or the facility will need to call before You are scheduled to be admitted. An urgent admission is a Hospital admission by a Physician due to the onset of or change in an Illness, the diagnosis of an Illness, or an Injury.
For outpatient non-emergency medical services requiring Preauthorization:	You or Your Physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to You and Your Physician of the Preauthorization decision, where required by state law. If Your Preauthorized services are approved, the approval is valid for 180 days as long as You remain enrolled in the plan.

When You have an inpatient admission to a facility, We will notify You, Your Physician and the facility about Your Preauthorized length of Stay. If Your Physician recommends that Your Stay be extended, additional days will need to be Preauthorized. You, Your Physician, or the facility will need to call Us at the number on Your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended Stay. You and Your Physician will receive a notification of an approval or denial.

If Preauthorization determines that the Stay or services and supplies are not Covered Benefits, the notification will explain why and how Our decision can be appealed. You or Your Provider may request a review of the Preauthorization decision. See the *When You disagree - Claims Determinations, Grievance and Appeals* section.

What if You don't obtain the required Preauthorization?

If You fail to seek Our Preauthorization or provide notification for benefits subject to this section, We will pay an amount of $400 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges; cost for services. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

What types of services require Preauthorization?

Preauthorization is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a hospital	Cosmetic and reconstructive surgery
Stays in a skilled nursing facility	Transcranial magnetic stimulation (TMS)
Stays in a rehabilitation facility	Applied behavior analysis
Stays in a hospice facility	Partial Hospitalization Treatment – Mental Disorder and Substance Abuse diagnoses
Stays in a residential treatment facility for treatment of mental disorders and substance abuse	
Bariatric surgery (obesity)	

Prescription drugs are covered under the medical plan when they are given to you by Your doctor or health care facility. The following information applies to these Prescription drugs:

Eligible Health Services under Your plan

The information in this section is the first step to understanding Your plan's Eligible Health Services.

Your plan covers many kinds of health care services and supplies, such as Physician care and Hospital Stays. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

Physician care generally is covered but Physician care for Cosmetic surgery is never covered. This is an exception (Exclusion).

Home Health Care is generally covered but it is a Covered Benefit only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the *Exclusions* section, and about the limitations in the Schedule of Benefits.

Important note: Sex-specific Eligible Health Services are covered when medically appropriate, regardless of identified gender.

We've grouped the health care services below to make it easier for You to find what You're looking for.

Preventive Care and Wellness

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care

We cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP").

However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of

Well-Baby and Well-Child Care

We cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per Calendar Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Adult Annual Physical Examinations

We cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website, log on to Your Aetna secure member website at www.aetna.com, or will be mailed to You upon request.

We also cover screening for diabetes after pregnancy for women with a history of diabetes during pregnancy and screening for urinary incontinence.

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer

We cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as
follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Family Planning and Reproductive Health Services

We cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug coverage section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not cover services related to the reversal of elective sterilizations.

Bone Mineral Density Measurements or Testing

We cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

Screening for Prostate Cancer

We cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Additional Preventive Screening and Counseling Services

We cover screening and counseling by Your Health Professional for some additional conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

Obesity and/or healthy diet counseling

Eligible Health Services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Misuse of alcohol and/or drugs

Eligible Health Services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

Use of tobacco products

Eligible Health Services include the following screening and counseling services to help You to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits
- Tobacco cessation prescription and over-the-counter drugs
    - Eligible Health Services include FDA- approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

Sexually transmitted infection counseling

Eligible Health Services include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic risk counseling for breast and ovarian cancer

Eligible Health Services include the counseling and evaluation services to help You assess whether or not You are at increased risk for breast and ovarian cancer.

> **Important note:**
> Sex-specific eligible health services are covered when medically appropriate, regardless of identified gender.

Physicians and other Health Professionals

Physician services

Eligible Health Services include services by Your Physician to treat an Illness or Injury. You can get those services:

- At the Physician's office
- In Your home
- In a Hospital
- From any other inpatient or outpatient facility
- By way of Telemedicine

> **Important note:**
> Your policy covers Telemedicine only when you get your consult through a Provider that has contracted with Aetna to offer these services.
>
> All in person office visits covered with a Behavioral Health Provider are also covered if you use Telemedicine instead.
>
> Telemedicine may have different cost sharing. See the Schedule of Benefits for more information.

Other services and supplies that Your Physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Alternatives to Physician office visits

Walk-In Clinic

Eligible Health Services include health care services provided at Walk-In Clinics for:

Hospital and other facility care

Hospital care

We Cover inpatient Hospital services for acute care or treatment given or ordered by a Health Care Professional for an Illness, Injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;

Inpatient Stay for Maternity Care

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The care also includes coverage for the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

Inpatient Stay for Mastectomy Care

We cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

End of Life Care

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will cover acute care provided in a licensed Article 28 Facility or acute care facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the facility. If We disagree with Your admission to the facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will cover and reimburse the facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse acute care at the facility's current Medicare acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare acute care rate.

Alternatives to Hospital Stays

Outpatient surgery and physician surgical services

We cover services provided and supplies used in connection with outpatient Surgery performed in a Surgery Center or a Hospital's outpatient department.

Important note:
Some Surgeries can be done safely in a Physician's office. For those Surgeries, your plan will pay only for Physician and not for a separate fee for facilities.

Home health care

We cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of

Emergency Services

We cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an "Emergency Condition" to mean: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also cover Emergency Services to treat Your Emergency Condition worldwide. However, We will cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of ergs

Emergency Hospital Admissions.

In the event that You are Admitted to the Hospital, You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

Specific conditions

Autism spectrum disorder

We cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

Screening and Diagnosis. We cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

Assistive Communication Devices. We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of a communication impairment. We do not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

We cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We cover one repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not cover delivery or service charges or routine maintenance.

Behavioral Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Provider. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

Pharmacy Care. We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

Limitations. We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

Birthing center

Diabetic equipment, supplies and education

We cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

Equipment and Supplies

We cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

Acetone reagent strips
Acetone reagent tablets
Alcohol or peroxide by the pint
Alcohol wipes
All insulin preparations
Automatic blood lance kit
Blood glucose kit
Blood glucose strips (test or reagent)
Blood glucose monitor with or without special features for visually impaired,
Blood glucose kit control solutions, and strips for home blood glucose monitor
Cartridges for the visually impaired
Diabetes data management systems
Disposable insulin and pen cartridges
Drawing-up devices for the visually impaired
Equipment for use of the pump
Glucagon for injection to increase blood glucose concentration
Glucose acetone reagent strips
Glucose reagent strips
Glucose reagent tape
Injection aides
Injector (Busher) Automatic
Insulin
Insulin cartridge delivery
Insulin infusion devices
Insulin pump
Lancets
Oral agents such as glucose tablets and gels
Oral anti-diabetic agents used to reduce blood sugar levels
Syringe with needle; sterile 1 cc box
Urine testing products for glucose and ketones
Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Self-Management Education

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Mental health treatment

Inpatient Services

We cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; and, in other states, to similarly licensed or certified facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

We also cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at facilities that provide residential treatment, including Room and Board charges. Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

Outpatient Services

We cover outpatient mental health care services, including but not limited to partial hospitalization program services and Intensive Outpatient Program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

Limitations/Terms of Coverage

We do not cover:

- Benefits or services deemed to be Cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for Youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

Please refer to the Schedule of Benefits section of this Certificate for Cost Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Important note:
Your plan covers Telemedicine only when you get your telephone or internet-based consult through an authorized internet service vendor who conducts Telemedicine consultations that has contracted with Aetna to offer these services. Provider search tells you who those are.

Substance Abuse

Inpatient Services

We cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

We also cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at facilities that provide residential treatment, including Room and Board charges. Coverage for residential treatment services is limited to OASAS-certified facilities defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2)and to services provided in such facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Outpatient Services

We cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication assisted treatment. Such coverage is limited to facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use disorder or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute Detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also cover up to 20 outpatient visits per Calendar Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use and/or dependency. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Please refer to the Schedule of Benefits section of this Certificate for Cost Sharing requirement, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Obesity (bariatric) surgery

We cover obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are Morbidly Obese, for the purpose of losing weight.

Obesity is typically diagnosed based on Your Body Mass Index (BMI). To determine whether You qualify for obesity surgery, Your doctor will consider Your BMI and any other condition or conditions You may have. Your doctor will request approval from Us in advance of Your Obesity surgery. We will cover charges made by a Network Provider for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
  Outpatient Prescription Drug benefits included under the *Outpatient Prescription Drugs* section

Health care services include one Obesity surgical procedure. However, Eligible Health Services also include a multi-stage procedure when planned and approved by Us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

Reconstructive Surgery (Other than Breast Reconstruction after a Mastectomy) 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 corrects an accidental Injury that happened no more than 24 months before Your Surgery. For a covered person under age 18, the time period for coverage may be extended through age 18. Injuries that occur during Surgical Procedures or medical treatments are not considered accidental Injuries, even if unplanned or unexpected.
- 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.

Treatment of infertility

We cover services for the diagnosis and treatment (surgical and medical) of Infertility when such Infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows:

Basic Infertility Services

Basic Infertility services will be provided to a Member who is an appropriate candidate for Infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and

- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.

Our NIU is here to help You. It is staffed by a dedicated team of registered nurses and Infertility coordinators with expertise in all areas of Infertility who can help:

- Enroll in the Infertility program.
- Assist You with precertification of Eligible Health Services.
- Coordinate precertification for comprehensive Infertility when these services are Eligible Health Services.
- Evaluate Your medical records to determine whether comprehensive Infertility services are reasonably likely to result in success.
- Determine whether comprehensive Infertility services are Eligible Health Services.

Your Provider will request approval from Us in advance for Your Infertility services. We will cover charges made by a network Infertility Specialist for the following Infertility services:

- Ovulation induction cycle(s) with menotropins.
- Intrauterine insemination.

A "cycle" is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

Advanced reproductive technology

Advanced Infertility Services

We Cover advanced infertility services.

Advanced infertility services include:

- In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs; and
- Cryopreservation and storage of embryos.

Exclusions and Limitations

We do not Cover:

- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for members acting as surrogate mothers); Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is

You are eligible for ART services if:

You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse, civil union partner, or domestic partner, referred to as "Your partner". Dependent children are covered under this plan for ART services only in the case of fertility preservation due to planned cancer treatment that will render the individual infertile.

There exists a condition that:

- Is demonstrated to cause the disease of infertility.
- Has been recognized by Your physician or infertility specialist and documented in Your or Your partner's medical records.

You have not had a voluntary sterilization (tubal ligation, hysterectomy and vasectomy) with or without surgical reversal, regardless of post reversal results.

A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.

You have exhausted the comprehensive Infertility services benefits or have 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.

Fertility preservation

Only cancer patients are eligible for fertility preservation. Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when You:

- Are believed to be fertile
- Have planned services that will result in Infertility such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapies
  - Ovarian or testicular removal

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

- You, Your partner or dependent child are planning treatment that is demonstrated to result in Infertility. Planned treatments include:
  - Bilateral orchiectomy (removal of both testicles)
  - Bilateral oophorectomy (removal of both ovaries)
  - Hysterectomy (removal of the uterus)
  - Chemotherapy or radiation therapy that is established in medical literature to result in Infertility

Eligible Health Services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are Infertile and not diagnosed with cancer.

Our National Infertility Unit (NIU) is here to help You. It is staffed by a dedicated team of registered nurses and Infertility coordinators with expertise in all areas of Infertility who can help:

- Enroll in the Infertility program.
- Assist You with Precertification of Eligible Health Services.
- Coordinate Precertification for ART services and fertility preservation services when these services are Eligible Health Services. Your Provider should obtain Precertification for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.
- Evaluate Your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are Eligible Health Services.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your Provider will request approval from Us in advance for Your ART services and fertility preservation services. We will cover charges made by a network ART Specialist for the following ART services:

- Any combination of the following ART services:
  - In vitro fertilization (IVF)*
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with Your care when using a gestational carrier including egg retrieval and culture and fertilization of Your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. *See the What Your plan doesn't cover – some eligible health services exceptions* section.

Charges associated with Your care when You will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into You.

Charges associated with obtaining sperm from Your partner when they are covered under this plan for ART services.

The procedures are done while not confined in a hospital or any other facility as an inpatient.

A "cycle" is an attempt at a particular type of Infertility treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, "one" cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to individuals who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. Eligible Health Services for ESET will be paid on the same basis as any other ART services benefit.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

We cover complex imaging services by a Provider, including:

Computed tomography (CT) scans

Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (*MRA*)

Outpatient infusion therapy

We cover infusion therapy You receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a Hospital
- A Physician in the office
- A home care Provider in Your home

Preadmission Testing

We cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;

Speech therapy, but only if it is expected to:

- Significantly improve or restore the speech function or correct a speech impairment as a result of an acute Illness, Injury or Surgical Procedure, or
- Improve delays in speech function development caused by a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

Cognitive rehabilitation associated with physical rehabilitation, but only when:

- Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
- The therapy is coordinated with Us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services for autism spectrum disorder treatment

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, and speech therapy

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.)

Telemedicine Program

We Cover online internet consultations between You and Providers who participate in Our Telemedicine program for medical conditions that are not an Emergency Condition.

Other services

Acupuncture

We cover the treatment by the use of acupuncture (manual or electroacupuncture) provided by Your Physician, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure

Ambulance service and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and Ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

Emergency Ambulance Transportation

We cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an Ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an Ambulance service issued a certificate under the New York Public Health Law. We will, however, only cover transportation to a Hospital provided by such an Ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

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

An Ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable.

In addition to Pre-Hospital Emergency Medical Services, We also cover emergency Ambulance transportation by a licensed Ambulance service (either ground, water or air Ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency Ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

Non-Emergency Ambulance Transportation

We cover non-emergency Ambulance transportation by a licensed service (either ground or air Ambulance, as appropriate) between Facilities when the transport is any of the following:

From a non-participating Hospital to a participating Hospital;
To a Hospital that provides a higher level of care that was not avai7AAB6(T)-1l Em eBA 11 Tf O Emerfr26.001.370

Limitations/Terms of Coverage

We do not cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.

We do not cover non-Ambulance transportation such as ambulette, van or taxi cab.

Coverage for air Ambulance related to an Emergency Condition or air Ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land Ambulance is not appropriate; and Your medical condition requires immediate and rapid Ambulance transportation that cannot be provided by land Ambulance; and one (1) of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Ambulatory Surgical Center Services

We cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed, when provided by a Participating Provider.

Chiropractic care

We cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this Certificate.

Clinical trials

We cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and

Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not cover:

the costs of the investigational drugs or devices;

the costs of non-health services required for You to receive the treatment;

the costs of managing the research; or

the costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

A federally funded or approved trial;

Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or

A drug trial that is exempt from having to make an investigational new drug application.

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.

Ostomy Equipment and Supplies

We Cover ostomy equipment and supplies prescribed or recommended by a Health Care Professional.

Prescription Drugs for Use in the Office and Outpatient Facilities

We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

Prosthetic devices

External Prosthetic Devices

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

We do not Cover orthotics (e.g., shoe inserts).

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Second Opinions

Second Cancer Opinion. We cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-Network basis when Your attending Physician provides a written Referral to a Non-participating Specialist.

Second Surgical Opinion. We cover a second surgical opinion by a qualified Physician on the need for Surgery.

Second Opinions in Other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that We designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to

Eligible Health Services under Your plan:

What does your outpatient prescription drug plan cover?

Any Pharmacy service that meets these three requirements:

- They are listed in the *Eligible Health Services under Your plan* section.
- They are not carved out in the *Exclusions* section.
- They are not beyond any limits in the Schedule of Benefits

Your plan benefits are covered when You follow the plan's general rules:

- You need a Prescription from Your Prescriber.
- Your drug needs to be Medically Necessary for Your Illness or Injury. See the *Medical Necessity and Precertification* requirements section.
- You need to show Your ID card to the Pharmacy when You get a Prescription filled.

Your outpatient Prescription Drug plan is based on drugs in the drug guide. The drug guide includes both Brand-Name Prescription Drugs and Generic Prescription Drugs. Your out-of-pocket costs may be higher if Your Prescriber prescribes a Prescription Drug not listed in the drug guide.

Generic Prescription Drugs may be substituted by Your pharmacist for Brand-Name Prescription Drugs. Your out-of-pocket costs may be less if You use a Generic Prescription Drug when available.

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

What Outpatient Prescription Drugs are covered

Your Prescriber may give You a Prescription in different ways, including:

- Writing out a Prescription that You then take to a Participating Pharmacy.
- Calling or e-mailing a Participating Pharmacy to order the medication.
- Submitting Your Prescription electronically.

Once You receive a Prescription from Your Prescriber, You may fill the Prescription at a Participating Retail, Mail Order or Specialty Pharmacy.

Retail Pharmacy

Generally, Retail Pharmacies may be used for up to a 30 day supply of Prescription Drugs except for contraceptive drugs or devices. You should show Your ID card to the Participating Pharmacy every time You get a Prescription filled. The Participating Pharmacy will calculate Your claim online. You will pay any cost sharing directly to the Participating Pharmacy.

You do not have to complete or submit claim forms. The Participating Pharmacy will take care of claim submission.

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. These drugs may be ordered through mail order after an initial 30 day supply with the exception of contraceptive drugs or devices which are available for an initial three month supply.

Outpatient Prescription Drugs are covered when dispensed by a Participating 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 Participating Mail Order Pharmacy.

Specialty Pharmacy

Diabetic supplies

Eligible Health Services include but are not limited to the following diabetic supplies upon Prescription by a Prescriber:

- Injection devices including insulin syringes, needles and pens

How You get an emergency Prescription filled

You may not have access to a Participating Pharmacy in an Emergency or Urgent Care situation, or You may be traveling outside of the plan's Service Area. If you must fill a Prescription in either situation, We will reimburse You as shown in the table below.

Type of Pharmacy	Your cost share
Participating Pharmacy	You pay the Copayment.

How Your outpatient Prescription Drug Deductible works

Your outpatient Prescription Drug Deductible is the amount You need to pay for outpatient Prescription Drug Eligible Health Services before Your plan begins to pay some or all of the expenses for outpatient Prescription Drug Eligible Health Services.

Your Schedule of Benefits shows the outpatient Prescription Drug Deductible amounts that apply to Your plan. Once You have met Your outpatient Prescription Drug Deductible, We will start sharing the cost when You get outpatient Prescription Drug Eligible Health Services. You will continue to pay Copayments for Covered Benefits after You satisfy any applicable Deductible.

How Your Copayment/Coinsurance works

Your Copayment/Coinsurance is the amount You pay for each Prescription fill or refill in addition to Your outpatient Prescription Drug Deductible. Your Schedule of Benefits shows You which Copayments/Coinsurance You need to pay for specific Prescription fill or refill. You will pay any cost sharing directly to the Participating Pharmacy.

How Your outpatient Prescription Drug Maximum Out-of-Pocket Limit works

You will pay Your outpatient Prescription Drug Deductible and Copayments/Coinsurance up to the outpatient Prescription Drug Maximum Out-of-Pocket Limit for Your plan.

Your Schedule of Benefits shows the outpatient Prescription Drug Maximum Out-of-Pocket Limits that apply to Your plan. Once You reach Your outpatient Prescription Drug Maximum Out-of-Pocket Limit, Your plan will pay for outpatient Prescription Drug Covered Benefits for the remainder of that Calendar Year.

What Preauthorization requirements apply

For certain drugs, You, Your Prescriber or Your pharmacist needs to get approval from Us before We will cover the drug. This is called "Preauthorization" The requirement for getting approval in advance guides appropriate use of preauthorized drugs and makes sure they are Medically Necessary. For the most up-to-date information,

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.

Prescribing units

Some outpatient Prescription Drugs are subject to quantity limits. These quantity limits help Your Prescriber and pharmacist check that Your outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

Some outpatient Prescription drugs are limited to 100 units dispensed per Prescription order or refill.

Any outpatient Prescription Drug that has duration of action extending beyond one (1) month shall require the number of Copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) Copayments.

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

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

What Your plan doesn't cover – Exclusions and limitations

No coverage is available under this Certificate for the following:

General exceptions

Aviation.

Experimental or Investigational Treatment.

We do not cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation.

We do not cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot Care.

We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Government Facility.

We do not cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Jaw joint disorder

Non-surgical treatment of Temporomandibular joint disorder (TMJ)

Medically Necessary.

In general, We will not cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise covered under the terms of this Certificate.

Medicare or Other Governmental Program.

No-Fault Automobile Insurance.

We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.

We do not cover services that are not listed in this Certificate as being covered.

Services Provided by a Family Member

We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Services Separately Billed by Hospital Employees

We do not cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge

We do not cover services for which no charge is normally made.

Vision Services

We do not cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Certificate.

War

We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation

Outpatient prescription drugs

Limitations/Terms of Coverage

We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding.

Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate. Your benefit for diabetic insulin, oral hypoglycemics, and diabetic Prescription Drugs, diabetic supplies, and equipment will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Additional Benefits, Equipment and Devices section of this Certificate.

We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.

We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this

We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.

A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

How do You choose Your PCP?

You can choose a PCP from the list of PCPs in Our Directory. See the *Who provides the care, Participating providers* section.

Each covered family member is encouraged to select their own PCP. You may each select Your own PCP. You should select a PCP for Your covered Dependent if they are a minor or cannot choose a PCP on their own.

What will Your PCP do for You?

Your PCP will coordinate Your medical care or may provide treatment. They may send You to other Participating Providers.

Your PCP can also:

- Order lab tests and radiological services.

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 a Non-Participating 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, the transitional period will include the time required for postpartum care directly related to the delivery.

We

The general rule

When You get Eligible Health Services:

You pay for the entire expense up to any Deductible limit.

And then

The plan and You share the expense. The Schedule of Benefits lists how much Your plan pays and how much You pay for each type of health care service. Your share is called a Copayment/Coinsurance.

And then

The plan pays the entire expense after You reach any Maximum Out-of-Pocket Limit.

When We say "expense" in this general rule, We mean the Recognized Charge for a Non-Participating Provider and Recognized Charge for an Non-Participating Provider. See the *Glossary* section for what these terms mean.

Important exception – when Your plan pays all

Under the Participating level of coverage, Your plan pays the entire expense for all Eligible Health Services under the preventive care and wellness benefit.

Important exceptions – when You pay all

Where Your Schedule of Benefits fits in

How Your Deductible works

Your Deductible is the amount You need to pay, after paying Your coinsurance, for Eligible Health Services per Calendar Year as listed in the Schedule of Benefits. Your coinsurance does not count toward Your Deductible.

How Your Copayment/Coinsurance works

Your Copayment/Coinsurance is the amount You pay for Eligible Health Services after You have paid Your Deductible. Your Schedule of Benefits shows You which Copayments/Coinsurance You need to pay for specific Eligible Health Services.

When you disagree - Claim Determinations, Grievance and Appeals procedures

Claim Determinations

A. Claims

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

B. Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 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.

C. Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or Experimental or Investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or Experimental or Investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations

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

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

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

G. Post-Service Claim Determinations

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

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

Grievance Procedures

A. Grievances

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

Expedited/Urgent Grievances: The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: 15 calendar days of receipt of Your Appeal.
(A request for a service or a

2. **Urgent Concurrent Reviews.**

Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

2. **Out-of-Network Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

    That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

    Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

Appeals

First Level Appeal

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal**. An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review,

Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Second Level Appeal
If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external Appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided

External Appeals

Your Right to an External Appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care or effectiveness of a Covered Benefit); or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  -

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

Your Right to Appeal a Determination that a Service is Out-of-Network

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

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

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

Your Right to Appeal an Out-of-Network Referral Denial

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

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

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

The External Appeal Process

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

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

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

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received

When coverage ends - Termination

Termination

13. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

Your employment ends because of a military leave of absence.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: Your coverage may continue until stopped by the policyholder but not beyond 36 months from the start of the absence.

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

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).

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

Extension of Benefits, Continuation of Coverage and Conversion

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Policy terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the Injury or sickness that is the cause of the total disability.

A. When You May Continue Benefits

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital Stay commencing, or Surgery performed, within 31 days from the date Your coverage ends. The Hospital Stay or Surgery must be for the treatment of the Injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total

A. Qualifying Events

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

- The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
- If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
- The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
- The date You become entitled to Medicare;
- The date to which Premiums are paid if You fail to make a timely payment; or
- The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

General provisions – other things you should know

Administrative provisions

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *When you disagree* - C*laim Determinations*, *Grievance and Appeals procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Time to Sue

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written

Glossary A-M

Aetna

Custodial Care
Services and supplies mainly intended to help meet Your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a Physician or given by trained medical personnel.

Deductible
The amount You pay for Eligible Health Services per Calendar Year before Your plan starts to pay as listed in the

Emergency Condition

A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

Group Policy

The Group Policy consists of several documents taken together. These documents are:

Is duly licensed by the agency responsible for licensing such Hospitals; and

Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Illness

Poor health resulting from disease of the body or mind.

Infertile/Infertility

A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Injury

Physical damage done to a person or part of their body.

Mail Order Pharmacy
A pharmacy where Prescription Drugs are legally dispensed by mail or other carrier.

Maximum Out-of-Pocket Limit
The maximum out-of-pocket amount for payment of Copayments and coinsurance including any Deductible, to be paid by You or any covered dependents per Calendar Year for Eligible Health Services.

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:

Negotiated Charge

For health coverage, this is either:

- The amount a Participating Provider has agreed to accept
- The amount we agree to pay directly to a Participating Provider or third party vendor (including any administrative fee in the amount paid)

for providing services, Prescription Drugs or supplies to plan members. This does not include Prescription Drug services from a network pharmacy.

For Prescription Drug services from a Participating Pharmacy:

Participating Pharmacy
A Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy that has contracted with Aetna, an affiliate, or a third party vendor, to provide outpatient Prescription Drugs to You.

Pharmacy
An establishment where Prescription Drugs are legally dispensed. This includes a Retail, Mail Order and Specialty Pharmacy.

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.

Preauthorization, Preauthorize
A requirement that You or Your Physician contact Aetna before You receive coverage for certain services. This may include a determination by Us as to whether the service is Medically Necessary and eligible for coverage.

Preferred Drug
A Prescription Drug or device that is listed on the Preferred Drug guide.

Preferred Drug Guide
A list of Prescription Drugs and devices established by Aetna or an affiliate. It does not include all Prescription Drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the Preferred Drug guide is available at Your request. Or You can find it on the Aetna website at www.aetna.com/formulary.

Preferred Network Pharmacy
A Network Retail Pharmacy that Aetna, has identified as a Participating Pharmacy.

Preferred Provider
A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

Premium
The amount You or the policyholder are required to pay to Aetna to continue coverage.

Prescriber
Any Provider acting within the scope of their license, who has the legal authority to write an order for outpatient Prescription Drugs.

Prescription
As to hearing care:
A written order for the dispensing of Prescription electronic hearing aids by otolaryngologist, otologist or audiologist.

As to Prescription Drugs:
A written order for the dispensing of a Prescription Drug by a Prescriber. If it is a verbal order, it must promptly be put in writing by the Participating Pharmacy.

As to vision care:
A written order for the dispensing of Prescription lenses or Prescription contact lenses by an ophthalmologist or optometrist.

Prescription Drug

A Drug, biological, or compounded Prescription which, by State and Federal Law, may be dispensed only by Prescription or administered by a person who is acting within his or her capacity as a paid Health Professional.

Primary care Physician (PCP)

A Physician who:

- The Directory lists as a PCP
- Is selected by a person from the list of PCPs in the Directory
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care Physician, an internist, a pediatrician, OB, GYN or OB/GYN
- Is shown on Aetna's records as Your PCP

Provider(s)

A Physician, other Health Professional, Hospital, Skilled Nursing Facility, Home Health Care Agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to

Special terms used

Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:

- The method CMS uses to set Medicare rates
- What other **providers** charge or accept as payment
- How much work it takes to perform a service
- Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

The duration and complexity of a service
When multiple procedures are billed at the same time, whether additional overhead is required
Whether an assistant surgeon is necessary for the service
If follow-up care is included
Whether other characteristics modify or make a particular service unique
When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
Generally accepted standards of medical and dental practice
The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services

Get the most value out of your benefits
We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on **Aetna's** secure member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to **Aetna's** secure member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

R.N.
A registered nurse.

Residential Treatment Facility (Mental Disorders)
Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment.

Residential Treatment Facility (Substance Abuse)
Coverage for residential treatment services is limited to OASAS-certified facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Retail Pharmacy
A community pharmacy that dispenses outpatient Prescription Drugs at retail prices.

Room and Board
A facility's charge for Your overnight Stay and other services and supplies expressed as a daily or weekly rate.

Schedule of Benefits
The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Semi-Private Room Rate
An institution's Room and Board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same Geographic Area.

Service Area
The Geographic Area where Participating Providers for this plan are located.

Surgery Center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient Surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare)

Surgery or Surgical Procedures

The diagnosis and treatment of Injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture,

Aetna Life Insurance Company

Amendment

Amendment effective date: January 1, 2022

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

The following replaces the Discount Programs provision of your Certificate.

Discount programs

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service Providers". These third party service Providers may pay us so that they can offer you their services.

Third party service Providers are independent contractors. The third party service Provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service Providers for the services they offer. You are responsible for paying for the discounted goods or services.

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

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

Amendment 1
Issue Date February 28, 2022

Aetna Life Insurance Company
Hartford, Connecticut 06156

CERTIFICATE RIDER

Policyholder: Pace University
Group Policy No GP-0181579
Effective Date: January 1, 2022

The following summarizes changes made in your Certificate of Insurance. This Rider is effective on the date shown above.

Wellness Benefits

Wellness Program

1. Purpose.
The purpose of this wellness program is to encourage you to take a more active role in managing your health and well-being.

2. Description.
We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

A health risk assessment tool
A designated smoking cessation program
A designated weight management program
A designated stress management program
A designated health or fitness incentive program
Designated online wellness activities
Designated healthy activities
Self-management of chronic diseases
Other programs we determine have a nexus to health

3. Eligibility.

Additional Information Provided by

Pace University

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

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

Name of Plan:
Pace University Health Plan

Employer Identification Number:
13-5562314

Plan Number:
510

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Pace University
100 Summit Lake Drive
Valhalla, NY 10599
Telephone Number: (914) 923-2714

Agent For Service of Legal Process:
Pace University
100 Summit Lake Drive
Valhalla, NY 10599

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

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by Vice President.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

Important disclosure information about HMO-based plans:

Plan name

Plan name

Plan name

Your rights to enroll later if you decide not to
enroll now..
More information is available upon request......................
New York State Out-of-Network Emergency and
Surprise Medical Bill
Assignment of Benefits form ....
Out-of-network reimbursement examples for
large
group coverage...

.28.354.1-NY (6/20)

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

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit Aetna.com/ individuals-families-health-insurance/document- library/documents/2019Disclosures/NCQA-MED- Disclosures-FI-SI.pdf

Features of a large group plan

If you're a member, not all of the information in this document applies to your specific plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and

events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

Important information for New York plans

Type of insurance coverage

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

Using your NY plan

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

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

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

Prospective reviews

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

If we need more information, we will request it within three calendar days. You or your doctor will

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

Urgent care

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

Claims for emergency care

We'll review the information when the claim comes in. If we think the e renderek the 0

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If you are not satisfied or if you need help

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

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

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

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

Internal appeals for utilization review determinations

You have the right to appoint a designee to handle your appeal. You, your designee and, in

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external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External 0 0 -1 0 21.60000 0 21.600(Exte)-1(r(r)-1(d)1

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

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

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

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

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

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

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

Member Services can help you with this request by calling the number on your Aetna ID card. You can also send a request to Aetna by writing to:
Aetna
Attn: CRC Requests 1800 E Interstate Ave
Bismarck, ND 58503

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

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

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

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

Protection from surprise bills

A surprise bill is a bill you receive for covered services performed by a nonparticipating physician at a

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New York State Out-of-Network Surprise Medical Bill Assignment of Benefits form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a nonparticipating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a nonparticipating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a nonparticipating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a nonparticipating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a nonparticipating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: ______________________________

Patient Address: ______________________________

Insurer Name: ______________________________

Patient Insurance ID No.:______________________________

Provider Name: Provider Telephone Number Tm [(Pat)-

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Out-of-network reimbursement examples for large group coverage

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

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

	UCR charge	Plan A Sample costs	Plan B Sample costs	Plan C Sample costs
Hospital services	$5,119	$3,916	$1,827	$1,827
Physician services	$1,600	$750	$350	$275
Anesthesia	$1,944	$417	$191	$150
Pathology	$263	$244	$114	$89
Total	$8,926	$5,326	$2,482	$2,3473t8(s)]

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Breast Reconstruction CPT4
codes Procedure: 19357
Anesthesia: 00402

	UCR charge	Plan A

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TY: 711

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

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

Confidentiality Notice

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

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

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

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

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

This continuation of coverage section applies only for the period of any approved family or medical leave