Open Access Aetna Select medical plan

Booklet

Prepared for:

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Third Party Administrative Services provided by
Aetna Life Insurance Company

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Welcome

At Aetna, your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it's our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction

This is your booklet. It describes your covered services – what they are and how to get them. It also describes how we manage the plan, according to our policies, and applicable laws and regulations. The schedule of benefits tells you how we share expenses for covered services and explains any limits. Together, these documents describe the benefits covered by your Employer's self-funded health benefit. Each may have amendments attached to them. These change or add to the document. This booklet takes the place of any others sent to you before.

It's really important that you read the entire booklet and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the Coordination of benefits, Effect of prior plan coverage section.

If you need help or more information, see the *Contact us* section below.

How we use words

When we use:

"You" and "your" we mean you and any covered dependents (if your plan allows dependent coverage)
"Us," "we," and "our", we mean Aetna Life Insurance Company (Aetna)
Words that are in bold, these are defined in the *Glossary* section

Contact us

Your plan includes the Aetna concierge program. It provides immediate access to consultants trained in the specific details of your plan.

For questions about your plan, you can contact us by:

Calling the toll-free number on your ID card
Writing us at 151 Farmington Ave, Hartford, CT 06156
Visiting https://www.aetna.com to access your member website

Your member website is available 24/7. With your member website, you can:

See your coverage, benefits and costs
Print an ID card and various forms
Find a provider, research providers, care and treatment options
View and manage claims
Find information on health and wellness

Your ID card

Show your ID card each time you get covered services from a provider. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need covered services, or if you lose it, you can print a temporary one using your member website.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, or categories of healthcare providers, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna

Behavioral health

Mental health treatment

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

Inpatient room and board at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility

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

- Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
- Individual, group, and family therapies for the treatment of mental health disorders
- Other outpatient mental health treatment such as:
  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
  - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician

Experimental or investigational therapies

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

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

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

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it

Emergency services

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an emergency medical condition in a hospital emergency room. You can get emergency services from network or out-of-network providers.

Your coverage for emergency services will continue until the following conditions are met:

- You are evaluated and your condition is stabilized and
- Your attending physician determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another provider if you need more care

If both of the above conditions are met and you continue to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements*

The -7282oll7282owi7282ng are no7282t covered services:

- Services provided in an educati7282onal o7282r training setti7282ng or to teach sign language
- V7282ocatio7282nal7282 rehabil7282itati7282on o7282r empl7282oyment co7282unseling

Home health care

Covered services include home heal7282th care p7282ro7282vi7282ded by a home health care agency in 7282the home
all7282 o-7282 the fol7282lo7282wi7282ng criteri7282a are met:

- You must essential7282ly be confi7282ned to7282 the ho7282me as an alternative to7282 a ho7282spi7282tal st
- Your physician orders7282 them
- The services take the pl7282ace o7282f a stay i7282n a hospital]TJ /FAAABA 1Tf [(L)-(or a)]TJ /FAAAAH 1Tf [(ski)(

Hospice care services provided by the providers below will be covered, even if the providers are not an employee of the hospice care agency responsible for your care:em Tf [1036(Psychol)-ol30331(415io)-1(nal)- /FAerapy

- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient prescription drugs
  - Psychological counseling

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

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

You are eligible for these covered services if:

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

Aetna's National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and precertification. You can call the NIU at 1-800-575-5999.

Your network provider will request approval from us in advance for your infertility services.

The following are not covered services:

- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.
- Treatment for dependent children.
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.

Jaw joint disorder treatment

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

The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome

The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following are not covered services:

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

Maternity and related newborn care

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

No less than 48 hours of inpatient care in a hospital after a vaginal delivery

No less than 96 hours of inpatient care in a hospital after a cesarean delivery

A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 1 home visits after delivery by a health care provider. Covered services also include services and supplies needed for circumcision by a provider.

The following are not covered services:

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

Obesity surgery and services

Obesity surgery is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your physician will determine whether you qualify for obesity surgery.

Covered services include:

An initial medical history and physical exam

Diagnostic tests given or ordered during the first exam

Outpatient prescription drugs included under the *Outpatient prescription drugs* section

An obesity surgical procedure

A multi-stage procedure when planned and approved by the plan

Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not covered services:

Weight management treatment

Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the booklet.

Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy

Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a physician, dentist and hospital:

- Cutting out:
  - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth.

Important note:

After you obtain your second fill at a network retail pharmacy, you must tell us whether you want to use your network mail order pharmacy benefit, a CVS pharmacy or continue to use your network retail pharmacy. See the *Contact us* section for how. If you don't tell us your choice, the next prescription refill and any other refills at a network retail pharmacy will not be covered. You can tell us at any time that you intend to use a network retail pharmacy for future prescription refills.

Specialty pharmacy

A specialty pharmacy may be used for up to a 30 day supply of a specialty prescription drug. You can view the list of specialty prescription drugs. See the *Contact us* section for how.

All specialty prescription drug fills including the first fill must be filled at a network specialty pharmacy unless it is an urgent situation.

Prudent Rx

You will automatically be enrolled in your Plan's co-payment assistance program administered by PrudentRx (but you can choose to opt-out by contacting PrudentRx). The PrudentRx Copay Program will assist you by helping you to enroll in these drug manufacturer copay assistance programs. If you or a covered family member are taking one or more medications included in the PrudentRx Copay Program drug list, PrudentRx will contact you with specific information about the program as it relates to your medication and will let you know if you are required to enroll in copay assistance for any medication that you take. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx to provide any additional information needed to enroll in the copay program.

With copayment assistance for covered specialty prescription drugs, you will pay no cost share. If you choose to not use the program, or don't complete any participation requirements of the program, then you will pay a cost share.

If you are taking a specialty prescription drug, included in the program, we'll contact you. If there are participation requirements, we'll let you know and provide any additional information needed to participate.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

Important note:
Your cost share for specialty prescription drugs, under the copayment assistance program, will not count toward your deductible or maximum out-of-pocket limit. This includes cost shares that you, the plan or the program pay. Cost share paid for a specialty prescription drug that is an essential health benefit will count toward your deductible or maximum-out-of pocket limit, if you have one.

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

How to get an emergency prescription filled

You may not have access to a network pharmacy in an emergency or urgent situation or you may be traveling outside of your plan's service area. If you must fill a prescription

Immunizations
Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Infertility drugs
Covered services include synthetic ovulation stimulant prescription drugs used to treat the underlying medical cause of infertility.

Obesity drugs
Covered services include prescription drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents.

You must be diagnosed by your provider, including a physical exam and outpatient diagnostic lab work, with one of the medical conditions listed here:

- Morbid obesity
- Obesity with one or more of the following obesity-related risk factors:
  - Coronary artery disease
  - Dyslipidemia (LDL and HDL cholesterol, triglycerides)
  - Hypertension
  - Obstructive sleep apnea
  - Type 2 diabetes mellitus

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs
Covered services include prescription drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs
Covered services include prescription drugs for the treatment of sexual dysfunction or enhancement.
For the most up-to-date information on covered prescription drugs and doses, contact us.

Tobacco cessation prescription and OTC drugs
Covered services include FDA approved prescription and OTC drugs to help stop the use of tobacco products. You must receive a prescription from your provider and submit the prescription to the pharmacy for processing.

The following are not covered services:

- Abortion drugs (except for abortion drugs dispensed by a provider, including a telemedicine provider)
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a covered service
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception

Prescription drugs:

That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide

That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not medically necessary or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation drugs, unless recommended by the USPSTF

We reserve the right to exclude:

A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide

Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

Preventive care

Preventive covered services are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a covered service isn't listed here under preventive care, it still may be covered under other covered services in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)

United States Preventive Services Task Force (USPSTF)

Health Resources and Services Administration

American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your physician or us. This information is also available at https://www.healthcare.gov/.

> Important note:
> Gender-specific preventive care benefits include covered services described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support provider.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services

Covered services include preventive screening and counseling by your health professional for:

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a physician or other provider on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a health professional.
- Voluntary sterilization including charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive covered services:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a health professional

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive covered services:

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

Prenatal care

Well woman preventive visits

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

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

Prosthetic device

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

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

Coverage includes:

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

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

The following are not covered services:

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

Reconstructive breast surgery and supplies

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

- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - Surgery on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Reconstructive surgery and supplies

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

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

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

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

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient hospital stay if they are part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a hospital, skilled nursing facility, or physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your physician. The services have to be performed by a:

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

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your provider must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or surgical procedure
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or surgical procedure
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology provider or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology provider. See *Diagnostic complex imaging services* above for more information.

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay.

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

Covered services include GCIT provided by a physician, hospital or other provider.

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT covered services include:

- Cellular immunotherapies.

Radiation therapy

Covered services include the following radiology services provided by a health professional:

Accelerated particles
Gamma ray
Mesons
Neutrons
Radioactive isotopes
Radiological services
Radium

Transplant services

Covered services include transplant services provided by a physician and hospital.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Covered services also include:

Travel and lodging expenses

If you are working with an IOE facility that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, to travel between home and the IOE facility

Coach class air fare, train or bus travel are examples of covered services

Network of transplant facilities

The following are not covered services:

Services and supplies furnished to a donor when the recipient is not a covered person

Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness

Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening emergency medical condition. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

Covered services include services and supplies to treat an urgent condition as described below:

Urgent condition within the network (in-network)

- If you need care for an urgent condition, you should first seek care through your physician, PCP. If your physician is not reasonably available, you may access urgent care from an urgent care center that is in-network.

Urgent condition outside the network (out-of-network)

- You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and the service can't be delayed.

If you go to an urgent care center for what is not an urgent condition, the plan may not cover your expenses. See the schedule of benefits for more information.

The following are not covered services:

Non-urgent care in an urgent care center

Vision care

Covered services include:

Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not covered services:

Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses

Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Walk-in clinic

Covered services include, but are not limited to, health care services provided through a walk-in clinic for:

Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions

Preventive care immunizations administered within the scope of the clinic's license

Telemedicine consultation

Individual screening and counseling services that will help you:

With obesity or healthy diet

To stop using tobacco products

General plan exclusions

The following are not covered services under your plan:

Behavioral health treatment

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except as described in the *Coverage and exclusions* section
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Coverage and exclusions*, *Transplant services* section

Cosmetic services and plastic surgery

Dental services

The following are not covered services:

Services normally covered under a dental plan

Dental implants

Educational services

Examples of these are:

Any service or supply for education, training or retraining services or testing. This includes:

- Special education
- Remedial education
- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Job training
- Job hardening programs

Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.

To buy coverage or to get or keep a license.

To travel

To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials.

Foot care

Routine services and supplies for the following:

Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails

Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

Treatment of calluses, bunion(tinm53}Tg ortr0 0 1 18 494.14001465 cm BT /FAAADA 11 Tf1 (nt,)1(-1(tin)-1lFAAAD

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

The following are not covered services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. Examples include:
  - Infusion
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

See the *How your plan works – Medical necessity and precertification requirements* section.

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing aids

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Prescription vitamins
- Medical foods
- Other nutritional items

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

Other primary payer

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

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Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the *Covered services and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services and exclusions* section
- Nicotine patches
- Gum

Treatment in a federal, state, or governmental entity

Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or inju02000TJ ET Q q72900391 cm BT 1 0 0 -10l(y)1(i)-gg 0 387.30 TJ ET Q 9 0 -1 0 23.90200043 Tm s1(n)

How your plan works

How your medical plan works while you are covered in-network

Your in-network coverage helps you get and pay for a lot of, but not all, health care services. The plan usually pays only when you use a network provider.

Providers

Our provider network is there to give you the care you need. You can find network providers and see important information about them by logging in to your member website. There you'll find our online provider directory. You may also contact us to ask for a copy of the directory. We update the online directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the network. See the Contact us section for more information.

You choose a PCP to oversee your care. Your PCP will provide routine care and send you to other providers when you need specialized care. Your plan may pay a bigger share for covered services you get through your PCP, so choose a PCP

How you choose your PCP
You can choose a PCP from the list of PCPs in our directory.

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

What your PCP will do for you
Your PCP will coordinate your medical care or may provide treatment. They may send you to other network providers.

Changing your PCP
You may change your PCP at any time by contacting us.

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

You may have to find a new provider when:

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

However, in some cases, you may be able to keep going to your current provider or facility to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels for up to 90 days of the provider or facility ceasing to be in our network. This is called continuity of care. If we know you are under an active treatment plan, we will notify you of the provider's or facility's contract termination and how you can submit a request to keep going to your current provider or facility. Contact us for additional information.

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

Medical necessity and precertification requirements

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

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Precertification

You need pre-approval from us for some covered services. Pre-approval is also called precertification.

In-network

Your network physician is responsible for obtaining any necessary precertification before you get the care. Network providers cannot bill you if they fail to ask us for precertification. But if your physician requests precertification and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Timeframes for precertification are listed below. For emergency services, precertification is not required, but you should notify us as shown.

To obtain precertification, contact us. You, your physician or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

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 injury.

We will tell you and your physician in writing of the precertification decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient stay in a facility, we will tell you, your physician and the facility about your precertified length of stay. If your physician recommends that you stay longer, the extra days will need to be precertified. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days.

If you or your provider request precertification and we don't approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification

Precertification is required for inpatient stays and certain outpatient services and supplies.

Contact us to get a complete list of the services that require precertification. The list may change from time to time.

Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification.

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.

Requesting a medical exception

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

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

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

What the plan pays and what you pay

Who pays for your covered services – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of covered service. In general, this is how your benefit works:

- You pay the deductible, when it applies.
- Then the plan and you share the expense. Your share is called a copayment or payment percentage.
- Then the plan pays the entire expense after you reach your maximum out-of-pocket limit.

When we say "expense" in this general rule, we mean the negotiated charge for a network provider.

Negotiated charge

For health coverage:

This is the amount a network provider has agreed to accept or that we have agreed to pay them or a third party vendor (inc(r)1(-1(s3tre)1(atmeis share)1(i)-1(s call)-1(e)1(d)-1(a)]TJ /FAAAAH 11 Tf [(c)-1(o)1(pa)1(ym)-1(en1 Tf [(networ

You pay the entire expense when:

- You get services or supplies that are not medically necessary.
- Your plan requires precertification, your physician requests it, we deny it and you get the services without precertification.
- You get care from someone who is not a network provider, except for emergency, urgent care and transplant services. See *Who provides the care* in this section for details.

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your deducti p-0Tm [towards you)-1r)(1)]TJ /ae entimum 0t -of-pockAAAAH 1limitcertification

How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare, even if you are not covered, if you refused it, dropped it, or didn't make a request for it.

Effect of prior plan coverage

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

Your current and prior plan must be offered through the same employer.

Other health coverage updates – contact information

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

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them. We will make a decision within 15 days.

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

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

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

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

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

Complaints, claim decisions and appeals procedures

The difference between a complaint and an appeal

A Complaint

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

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Claim decisions and appeal procedures

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

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having you fill out an authorized representative form telling us that you are allowing the provider to appeal for you.

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

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

Appeal through an external review process.
Pursue arbitration, litigation or other type of administrative proceeding.

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

You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:

- The rule violation was minor and not likely to influence a decision or harm you.
- The violation was for a good cause or beyond our control.
- The violation was part of an ongoing, good faith exchange between you and us.

External review

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

You have a right to external review only if:

Our claim decision involved medical judgment.
We decided the service or supply is not medically necessary or not appropriate.
We decided the service or supply is experimental or investigational.
You have received an adverse determination.

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

Your employer decides and tells us who is eligible for health coverage.

When you can join the plan

You must live or work in the service area to enroll in this plan.

You can enroll:

- At the end of any waiting period your employer requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your "dependents") at this time too.
If you don't enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Dependent children – yours or your spouse's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state fee assistance under Medicaid or S-CHIP which will pay your fee contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your employer to confirm your effective date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- Your employer asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

Your coverage may end if you act in a way that prevents you from having a good relationship with a network provider. We may also end your coverage if you act in a way that affects our business operations. We will give you 30 days notice in writing if we end your coverage for any of these reasons.

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

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

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact your employer to see what options apply to you.

In some cases, fee payment is required for coverage to continue. Your coverage will continue under the plan as long as your employer and we have agreed to do so. It is your employer's responsibility to let us know when your work ends. If your employer and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

How you can extend coverage for your disabled child beyond the plan age limits

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

The right to coverage will continue only as long as a physician certifies that your child still is disabled.

We may ask you to send us proof of the1(o)-1(v)4d4bl(stil)10.473ntAllooTh 473tin1(d usl of thto exd)-1(bey)1d.di0% of2

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet

We prepared this booklet according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage.

How Aetna administers this plan

Aetna will administer the Plan in accordance with this booklet and apply policies and procedures which Aetna has developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even network providers are not our employees or agents.

Claim administrator

Aetna's authority as claim administrator

Aetna has been designated as claims administrator for benefits under the Plan with full discretion and authority to make claim and appeal determinations. The claims administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Coverage and services

Your coverage can change

Your coverage is defined by the group contract. This document may have amendments too. Under certain circumstances, we, the Customer/Employer or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the Customer/Employer or provider, can do this.

Physical examination and evaluations

At our expense, we have the right to have a physician of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of physicians and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the Customer/Employer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in contributions or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an appeal
- You have the right to a third party review conducted by an independent ERO

Some other money issues

Legal action

You must complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions, and, appeal procedures* section.
You cannot take any action until 60 days after we receive written submission of a claim.

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

Assignment of benefits

When you see a network provider, they will usually bill us directly. When you see an out-of-network provider, we may choose to pay you or to pay the provider directly. To the extent allowed by law, we will not accept an assignment to an out-of-network provider.

Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for covered services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx

Recovery of overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.

Sutter Health and Affiliates Services

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.

Glossary

Behavioral health provider

A health professional who is licensed or certified to provide covered services for mental health and substance related disorders in the state where the person practices.

Brand-name prescription drug

An FDA-approved drug marketed with a specific name or trademark name by the company that manufactures it; often the same company that developed and patents it.

Copay, copayment

Emergency services

Treatment given in a hospital's emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the emergency medical condition. An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a d

Infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
- For an individual or their partner who has been clinically diagnosed with gender dysphoria

Jaw joint disorder

This is:

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

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 limit is the most a covered person will pay per year in copayments, contribution and deductible, if any, for covered services.

Mental health disorder

A mental health disorder is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of mental health disorder is in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association*.

Negotiated charge

See *How your plan works – What the plan pays and what you pay*.

Network provider

A provider listed in the directory for your plan. A NAP provider listed in the NAP directory is not a network provider.

Out-of-network provider

A provider who is not a network provider.

Payment Percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Physician

A health professional trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a physician can also be a primary care physician (PCP).

Precertification, precertify

Pre-approval that you or your provider receives from us before you receive certain covered services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Prescription

This is an instruction written by a physician or other provider that authorizes a patient to receive a service, supply, medicine or treatment.

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 covered person
- Shows in our records as your PCP

A PCP can be any of the following providers:

- General practitioner
- Family physician
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

Provider

A physician, pharmacist, health professional, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

An institution licensed or certified as a psychiatric hospital by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or mental health disorders (including substance related disorders).

Residential treatment facility

An institution specifically licensed as a residential treatment facility by applicable laws to provide for mental health or substance related disorder residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:
For residential treatment programs treating mental health disorders:

- A behavioral health provider must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

For substance related residential treatment programs:

- A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a physician
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

For detoxification programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the di prdeno30 surson, (licephysiic

Skilled nursing facility

A facility specifically licensed as a skilled nursing facility by applicable laws to provide skilled nursing care. Skilled nursing facilities also include:

- Rehabilitation hospitals
- Portions of a rehabilitation hospital
- A hospital designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders.

Specialist

A physician who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drug

An FDA-approved prescription drug that typ40 0 l sta drug

Surgery, surgical procedure

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
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telemedicine

A consultation between you and a physician, specialist

Additional Information Provided by

Yeshiva University

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan:
Yeshiva University Health and Welfare Plan

Employer Identification Number:
13-1624225

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Yeshiva University
500 West 185th Street
New York, NY 10033
Telephone Number: (646) 592-4337

Agent For Service of Legal Process:
Yeshiva University
500 West 185th Street
New York, NY 10033

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 the Director of Benefits.

ERISA Rights

As a participant in the group benefit 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

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

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

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

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your

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

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

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

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

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

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

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

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

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