BENEFIT PLAN

Prepared Exclusively For
Pace University

Open Access Managed Choice Extraterritorial Riders

Extraterritorial Riders

Aetna Life Insurance Company

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

Table of Contents

Claim decisions and appeal procedures

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

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

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

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

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

Exhaustion of appeal process

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

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

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

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

A female 35 years of age or older without a male partner	Does not apply	At least 6 cycles of donor insemination	6 months	If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40
A male of any age with a female partner under 35 years of age	12 months or more	Does not apply	Does not apply	Does not apply
A male of any age with a female partner 35 years of age or older	6 months or more	Does not apply	Does not apply	Does not apply

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

Enroll in the infertility program.

Assist you with precertification of eligible health services.

Coordinate precertification for comprehensive infertility when these services are eligible health services.

Evaluate your medical records to determine whether comprehensive infertility services are reasonably likely to result in success.

- Determine whether comprehensive infertility services are eligible health services.

Your provider will request approval from us in advance for your infertility services. We will cover charges made by an infertility specialist for the following infertility services:

Ovulation induction cycle(s) with menotropins.

Intrauterine insemination.

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

Advanced reproductive technology

Eligible health services include Assisted Reproductive Technology (ART). ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

You are eligible for ART services if:

You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse or domestic partner, referred to as "your partner". Dependent children are covered under this plan for ART services only in the case of fertility preservation due to planned treatment for medical conditions that will result in infertility.

There exists a condition that:

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

You or your partner has not had a voluntary sterilization, 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.

You or your partner does not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).

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

You have exhausted the comprehensive infertility services benefits or have a clinical need to move on to ART procedures.

You have met the requirement for the number of months trying to conceive through egg and sperm contact.

Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

You are	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles: Self paid/not paid for by plan	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:

A female 35 years of age or older with a male partner	A. 6 months or more or	B. At least 6 cycles of

If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

Fertility preservation

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

Are believed to be infertile

Have planned services that will result in infertility such as:

- Chemotherapy
- Pelvic radiotherapy
- Other gonadotoxic therapies
- Ovarian or testicular removal

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

You, your partner or dependent child are planning treatment that is demonstrated to result in infertility. Planned treatments include:

- Bilateral orchiectomy (removal of both testicles)
- Bilateral oophorectomy (removal of both ovaries)
- Hysterectomy (removal of the uterus)
- Chemotherapy or radiation therapy that is established in medical literature to result in infertility

The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40.

Eligible health services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are infertile.

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

Enroll in the infertility program.

Assist you with precertification of eligible health services.

Coordinate precertification for ART services and fertility preservation services when these services are eligible health services. Your provider should obtain precertification for fertility preservation services through the NIU either directly or through a reproductive endocrinologist.

Evaluate your medical records to determine whether ART services and fertility preservation services are

reasonably likely to result in success.
Determine whether ART services and fertility preservation services are eligible health services.
Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your provider will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services:

- Any combination of the following ART services:
  - In vitro fertilization (IVF)*
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))

  Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
  Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. (See the *What your plan doesn't cover - some eligible health service exceptions* section.)
  Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
  Charges associated with obtaining sperm from your partner when they are covered under this plan for ART services.

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in Colorado. The benefits below will apply instead of those in your booklet-certificate.

Cleft Palate and Cleft Lip Conditions

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

Services and supplies include:

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

The following are not covered services:

Services and supplies related to data collection and record-keeping needed only for the clinical trial

Services and supplies provided by the trial sponsor for free

The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

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

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

The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required

The clinical trial has been approved by an institutional review board that will oversee it

The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:

- It conforms to standards of the NCI or other applicable federal organization
- It takes place at an NCI-designated cancer center or at more than one institution

You are treated in accordance with the procedures of that study

Early intervention services

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

Covered services include:

Speech and language therapy

Occupational therapy

Physical therapy

Assistive technology

Maternity and related newborn care

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

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

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

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

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

The following are not covered services:

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

Nutritional support Missed abortion

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

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

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

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Other nutritional items

Vision care

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

Complications of pregnancy

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

Acute nephritis
Nephrosis
Cardiac decompensation
Missed abortion
Non-elective cesarean section
Termination of ectopic pregnancy
Missed abortion

Telemedicine

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

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

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

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

Amendment: Colorado Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in Connecticut. The benefits below will apply instead of those in your booklet-certificate.

Precertification

Failure to pre-certify your eligible health services when required will result in a benefit reduction. Covered benefits will never be reduced by more than 50% of the benefits that would have been payable or $500, whichever is less.

How COB works with Medicare

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

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

Amendment: Connecticut Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

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

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

Mental health treatment

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

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

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

- Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist,

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

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

Substance related disorders treatment

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

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

Treatment of substance related disorders in a general medical hospital is only covered if you are admitted to the hospital's separate substance related disorders section or unit, unless you are admitted for the treatment of medical complications of substance related disorders.

As used here, "medical complications" include, but are not limited to:

- Electrolyte imbalances
- Malnutrition
- Cirrhosis of the liver
- Delirium tremens
- Hepatitis

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

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

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

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

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

Amendment: Delaware Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

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

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

Cleft lip and palate

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

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

Jaw joint disorder treatment

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

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

In no event will the covered amount for any covered service or treatment that is not available from an In-

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

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Jaw joint disorder treatment

Covered services

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

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

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

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

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

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

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

Abortion

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

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

Immunizations

Covered services include preventive immunizations for infectious diseases.

Doses, recommended ages and recommended population vary.

Adults:

- Herpes Zoster
- Mumps
- Rubella

Adults and children from birth to age 18

- Diphtheria
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu shot)
- Measles
- Meningococcal
- Pertussis (whooping cough)
- Pneumococcal
- Tetanus
- Varicella (chickenpox)
- Shingles if you are 60 years of age or over

Children from birth to age 18:

- Haemophilus influenza type b
- Inactive poliovirus
- Rotavirus

The following are not preventive covered services:

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

Low dose mammography screening, for women age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:

- For women 35-39, a baseline mammogram
- For women 40 years of age and older, annually
- For women under 40, with a family or prior personal history of breast cancer, positive genetic testing, or other risk factors, at necessary age and intervals
- Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogenous or dense breast tissue, as determined by your physician
- Screening MRI, as determined by your physician

Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your, PCP. This includes:

- Asymptomatic men age 50 and older
- African-American men age 40 and over
- Men age 40 and over with family history of prostate cancer
- Colorectal cancer screening for adults over 50

Colonoscopies including pre-procedure specialist

Fecal occult blood tests (FOBT)

Lung cancer screenings: adults age 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years

Sigmoidoscopies

Well woman preventive visits

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

Office visit to a physician, PCP, OB, GYN or OB/GYN for services including annual Pap smears including surveillance tests for ovarian cancer for women at risk for ovarian cancer.

Preventive care breast cancer (BRCA) gene blood testing

Clinical breast exams as follows:

- For women over 20 years of age but less than 40, at least every 3 years
- For women 40 years of age and older, annually

Breast cancer chemoprevention counseling

Cervical cancer screening for sexually active women

Chlamydia infection screening for younger women and other women at higher risk

HIV screening and counseling for sexually active women

Osteoporosis screening for women over age 60 depending on risk factors

Screening for diabetes during pregnancy for women with a history of diabetes during pregnancy

Screening for urinary incontinence

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

Anemia screening on a routine basis

Folic acid supplements for women who may become pregnant

Gonorrhea screening for all women at higher risk

Rh incompatibility screening for all pregnant women ABA 1porosis screening for women over age 60 depending c

Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.

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

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

These dental related services are limited to:

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

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

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

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

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

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

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

Requesting a medical exception

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

Not covered
Discontinued (for reasons other than safety or drug manufacturer withdrawal)
Ineffective in the treatment of your disease or medical condition
Likely to be ineffective or adversely affect the drug's effectiveness or patient compliance based on:

- Your known relevant physical and mental characteristics
- The known characteristics of the drug regimen from a step therapy requirement or dosage limitation

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

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

Contacting our Precertification Department at 1-855-582-2025

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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Physician profiling

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

Maximum coinsurance differential for network plans

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

Clinical trials

Routine patient costs

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

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

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

The following are not covered services:

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

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

You are eligible for these covered services if:

You or your partner have been diagnosed with infertility

You have met the requirement for the number of months trying to conceive through egg and sperm contact

Aetna's National Infertility Unit

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

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

Advanced reproductive technology (ART)

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

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

You are eligible for ART services if:

You or your partner have been diagnosed with infertility

You have exhausted comprehensive infertility services benefits or have a clinical need to move on to ART procedures

You have met the requirement for the number of months trying to conceive through egg and sperm contact

Aetna's National Infertility Unit

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

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

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

Covered services for fertility preservation are provided when:

You are believed to be fertile

You have planned services that are proven to result in infertility such as:

- Chemotherapy or radiation therapy that is established in medical literature to result in infertility
- Other gonadotoxic therapies
- Removing the uterus
- Removing both ovaries or testicles

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

The following are not covered services:

All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.

Home ovulation prediction kits or home pregnancy tests.

The purchase of donor embryos, donor eggs or donor sperm.

The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.

A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.

Obtaining sperm from a person not covered under this plan.

Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.

Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.

Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.

Treatment for dependent children, except for fertility preservation as described above.

Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.

Maternity and related newborn care

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

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

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

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

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

The following are not covered services:

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

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

MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy.

Elective Abortion

Unless coverage is provided under a policy issued in the state of Missouri, or a religious affiliated employer has elected not to provide, covered services also include the services and supplies provided for the voluntary termination of a pregnancy performed by a health professional.

Hearing aids

Hearing aid means:

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

Parts, attachments or accessories

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

Audiometric hearing visit and evaluation for a hearing aid prescription performed by:

- A physician certified as an otolaryngologist or otologist
- An audiologist who:
  - Is legally qualified in audiology
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist

Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam

Any other related services necessary to access, select, and adjust or fit a hearing aid

The maximum benefit payable is limited to $3,000 per hearing aid for each hearing-impaired ear every 36 months.

The following are not covered services:

Replacement of:

- A hearing aid that is lost, stolen or broken
- A hearing aid installed within a 36 month period

Replacement parts or repairs for a hearing aid

Batteries or cords

A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

Room and board

Services and supplies furnished to you on an inpatient or outpatient basis

Services by a hospice care agency or hospice care provided in a hospital

Psychological and dietary counseling

Pain management and symptom control

Bereavement counseling

Respite care

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:

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
- Dietary counseling

The following are not covered services:

Funeral arrangements

Financial or legal counseling including estate planning and the drafting of a will

Homemaker services, caretaker services, or any other services not solely related to your care, which may include:

- Sitter or companion services for you or other family members
- Transportation
- Maintenance of the house

Nutritional support

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

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

Covered services also include amino based elemental infant formula for any of the following documented conditions in children 2 and under:

Symptomatic allergic colitis and proctitis

Laboratory or biopsy proven allergic or eosinphillic gastroenteritis

History of anaphylaxis

Gastresophageal reflux disease

Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a provider

Cystic fibrosis

Malabsorption of cow-milk based or soy-milk based infant formula

The submitted documentation for the above mentioned conditions must show:

The formula is medically necessary as defined by Maine law

The formula is 50% or more the primary nutrition source

Other commercial infant formulas, including cow and soy milks, have been tried, failed or are contraindicated.

The following are not covered services:

Any food item, including:

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

Routine Cancer Screenings

Mammograms under the Routine Cancer Screening benefit also include an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

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
- Benefits equal to the limits provided by Medicare law

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

The following are not covered services:

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

Protection from surprise bills

In cases where you try to stay in the network or unknowingly go out-of-network for your covered services, you may get a bill you didn't expect. The plan may have approved coverage but you went outside the network without even knowing it.

When you're a patient in a hospital, the hospital may be in the network but some services you receive can be from doctors and labs who are not in the network. You can tell the hospital staff to only use network services during your stay, but that's not always possible. When you don't know or have no choice, you will pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for

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. We will process your request through our standard medical exception process within 72 hours or 2 business days, whichever is less, after receipt. If approved, you may receive the non-preferred drug benefit level and the exception will apply for the entire time you are taking the prescription. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

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

Contacting our Precertification Department at 1-855-582-2025

Faxing the request to 1-855-330-1716

Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

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

Continuity of prescription drugs

If you are undergoing a course of treatment with a previously authorized prescription drug from another carrier and your coverage is replaced by this coverage, we will honor the prior carrier's authorization. We will continue to provide coverage in the same manner until we review the authorization with your prescriber.

Why would we end your coverage?

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage.

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

Reinstatement due to cognitive impairment or functional incapacity

You may tell us if you would like a representative appointed or changed for notifications. If we discontinue coverage for failure to pay your premium, you or your representative, will receive the notification for termination 10 days before the termination date. You or your representative may submit a request for reinstatement within 90 days of the notice, showing that your failure to pay was due to native impairment or functional incapacity.

We may request medical documentation, at your expense, documenting the diminished capacity.

How you can extend coverage if your coverage ends because you are laid-off or you sustain an injury or disease compensable under Workers' Compensation

If you are totally disabled when coverage ends, coverage for you and your dependents may be extended if your coverage ended because:

- You are temporarily laid-off
- You are permanently laid-off and are eligible for premium assistance pursuant to federal law; or
- You sustain an injury or disease that you claim to be compensable under Workers' Compensation law.

You are eligible to extend your coverage under this provision if:

- You had group health coverage continuously under this plan for the last 6 consecutive months

Your dependents are eligible to extend coverage under this provision if:

- They had group coverage continuously under this plan for the last 3 consecutive months, unless they were not eligible for coverage until after the beginning of that 3 month period

You may extend coverage until the earliest of:

- When you become covered by another health benefits plan
- 12 months from the date of last employment
- The date the Workers' Compensation Board determines that the injury or disease that entitles you to continue coverage under this provision is not compensable under applicable Workers' Compensation law
- You fail to pay any required extension premium

We will extend your coverage only if you pay extension premiums. You must pay your first extension premium within 31 days after your coverage ends. Your extension premium may be up to 102% of the premium charged to a member who whose coverage has not ended.

Provider

A provider under your plan is defined as a physician, 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.

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

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

Amendment: Maine Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in Michigan. The benefits below will apply instead of those in your booklet-certificate.

Elective Abortions

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

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

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

Amendment: Michigan Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

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

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

Covered services include:

Services

- Foot care to minimize the risk of infection

Supplies

- Injection devices including syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

Equipment

- External insulin pumps and pump supplies
- Blood glucose monitors without special features, unless required due to blindness

Prescribed self-care programs with a health care provider certified in diabetes self-care training, including medical nutrition therapy

Durable medical equipment (DME)

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

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

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

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

Covered services also include:

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

The following are not covered services:

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

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

The following are not covered services:

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

Hospital care

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

- Semi-private room and board (your plan will cover the extra expense of a private room when appropriate because of your medical conditionAAEH 11 Tf 1 0 0 -1 0 11.0m2ul.4349795 cm BT /FAAAEH 11 Tf 1 0

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

The following are not covered services:

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items.

Pediatric streptococcal conditions

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

Behavioral therapies to manage neuropsychiatric symptoms
Plasma exchange
Immunoglobin
Antibiotics and medications

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

Port wine stain elimination

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

Anti-cancer drugs taken by mouth, including chemotherapy drugs

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

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

Anti-psychotic prescription drugs

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

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

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

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

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

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

The preferred drug guide changes
You change health plans

In order to be eligible for continuity of care:

You must have been treated with the prescription drug for 90 days prior to the change
Your prescriber must:

- Indicate to the pharmacy, verbally or in writing that the prescription must be dispensed as communicated
- Certify in writing to us that the prescription drug will best treat your condition

The continuing care benefit will be extended annually when:

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

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

Preferred drug guide prescription drug

- Caused an adverse reaction
- Is contradicted for you

Prescription drug must be Dispensed as Written (DAW) to provide maximum medical benefits to you

Prosthetic devices

A prosthetic device is

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

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

Coverage includes:

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

Surprise Bill

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

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

Emergency services provided by an out-of-network provider, including independent freestanding emergency departments. Your final diagnosis will not determine whether services are emergency services.

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

Non-emergency surgical or ancillary services provided by an out-of-network provider at an in-network facility, except when the non-participating provider has satisfied the notice and consent criteria for out-of-network cost shares by:

- Providing out-of-network notice to you of the estimated charges for the items and services and that the provider is a non- participating provider
- Obtaining consent from you to be treated and balance billed by the non-participating provider.
- Providing written notice and obtaining consent within 72 hours of the item or service being delivered or, if the item or service is scheduled within that timeframe, at the time the appointment is made.

Surgical or ancillary services mean any professional services including surgery, anesthesiology, pathology,

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

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

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

Pre-service claim

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

The benefit payment determination is made based on many things, such as your deductible or coinsurance, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your

How your dependent can extend coverage after you die

Your dependents can continue coverage after your death if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When you are injured

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

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

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

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

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

At risk for breast cancer

At risk for breast cancer is any of the following:

Having a family history with one or more first or second degree relatives with breast cancer

Testing positive for BRCA1 or BRCA2 mutations

Having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology

Having a previous diagnosis of breast cancer.

At risk for ovarian cancer

At risk for ovarian cancer is any of the following:

Having a family history:

- With one or more first or second degree relatives with ovarian cancer
- Of clusters of women relatives with breast cancer
- Of nonpolyposis colorectal cancer

Testing positive for BRCA1 or BRCA2 mutations

Child health supervision

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

Pediatric preventive services

Immunizations

Developmental assessments

Laboratory services

Child health supervision age ranges and frequency are:

Birth to 12 months, at least 5 visits

12-24 months, 3 visits

24-72 months, 1 per year

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

Jaw joint disorder

This is:

A temporomandibular joint (TMJ) dysfunction, craniomandibular disorder or any similar disorder of the jaw joint

A myofascial pain dysfunction (MPD) of the jaw

Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Medically necessary, medical necessity

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

In accordance with generally accepted standards of medical practice

Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease

Generally accepted standards of medical practice mean:

Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community

Following the standards set forth in our clinical policies and applying clinical judgment

Telehealth

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

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

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

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

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

Amendment: Minnesota Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

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

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

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

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or to the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

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

Payment of claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care

provider shall be notified of such payment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

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

Appeal

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

The ERO will:

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

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

How long will it take to get an ERO decision?

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

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

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

For initial adverse benefit determinations

- Your provider tells us a delay in receiving health care services would:
  - Jeopardize your life, health or a0 0 1 q 1 0 0 [1087(Jeop)-1(ar)1(dY)1(os wo)gai us o sh Jeopardize yBe m

Recordkeeping

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

Fees and expenses

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

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

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

Amendment: Mississippi Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in New Jersey. The benefits below will apply instead of those in your booklet-certificate.

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

Civil union partners

If your plan includes coverage for dependents, you can also enroll the following family members on your plan.

Your civil union partner who meets any policyholder rules and requirements under state law.

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

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

Amendment: New Jersey Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

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

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

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician

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

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

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

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

Amendment: Pennsylvania Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in Tennessee. The benefits below will apply instead of

Recovery of overpayments

We sometimes pay too much for covered services or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your provider, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake up to 18 months after the overpayment was received, except in cases of fraud.

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

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

Amendment: Tennessee Medical ET
Issue Date: January 23, 2023

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in Texas. The benefits below will apply instead of those in your booklet-certificate.

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

The insurance policy under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Underwritten by Aetna Life Insurance Company

The following content is added or replaced in the *Coverage and Exclusions* section of your booklet-certificate:

Autism spectrum disorder

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder – not otherwise specified.

Covered services include the "generally recognized services provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan. You can receive treatment from a provider that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States.
- Is certified as a provider under the 1(c)14276(Is)-1(c)1(ertifi)- Tm [States.)]TJ ET Q ET t

Cardiovascular disease testing

Covered services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

Diabetes

An intermediate or higher risk of getting coronary heart disease based on Framingham Heart Study prediction algorithms

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

Computed tomography (CT) scanning

Ultrasonography

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a provider in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial as a qualified individual for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

Federally funded trials:

- The study or investigation is approved or funded by one or more of the following:
  - The National Institutes of Health
  - The Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The Centers for Medicare & Medicaid Services
  - Cooperative group or center of any of the entities described above or the Department

Experimental or investigational therapies

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

- Standard therapies have not been effective or are not appropriate
- Your provider determines, and we agree, that based on published, peer-reviewed scientific evidence you may benefit from the treatment

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

Covered services also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- Prescribed by your provider
- Sent to us in writing by your provider

All supplies, including medications and equipment for diabetes will be dispensed as written, and are not subject to preauthorization or step therapy requirements.

Diagnostic follow-up care related to newborn hearing screening

Covered services include necessary diagnostic follow-up care related to the newborn hearing screening test from birth through 24 months of age.

Important Note:
Once you have met your deductible, your cost share for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging will be the same as mammograms performed for routine cancer screenings as described in the *Preventive Care* section when it is used to evaluate a breast abnormality detected by a physician or patient, or where there is a personal history of breast cancer or dense breast tissue.

This diagnostic imaging is not subject to any age limitations

Early intervention services for children with developmental delays

Covered services for a child with developmental delays include:

- Occupational therapy evaluations and services
- Physical therapy evaluations and services
- Speech therapy evaluations and services
- Dietary or nutritional evaluations

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate

If the child is homebound, therapy services may be provided in the child's home.

Emergency services

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

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

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation required by state or federal law and provided to covered enrollees in a hospital emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an emergency medical condition exists.
- Treatment to stabilize your condition.

Care in an emergency facility, freestanding emergency care facility or comparable facility after you become stable. But only if the treating provider asks us, and we approve the service. We will approve or deny the request within an hour after receiving the request.

As always, you can get emergency services from network providers. However, you can also get emergency services from out-of-network providers

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

Audiometric hearing visit and evaluation for a hearing aid prescription performed by:

- A physician certified as an otolaryngologist or otologist
- An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist

Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam

Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:

Replacement of a hearing aid that is lost, stolen or broken

Replacement parts or repairs for a hearing aid

Batteries or cords

A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Home health care

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

Your physician orders them

The services take the place of a stay in a hospital or a skilled nursing facility

The services are a part of a home health care plan

The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including care and services for complications of pregnancy.

Complications of pregnancy are:

Conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:

- Acute nephritis
- Nephrosis
- Cardiac decompensation
- Missed abortion
- Similar medical and surgical conditions of comparable severity

The following conditions that occur during a period of gestation in which a viable birth is not possible:

- Non-elective cesarean section
- Termination of ectopic pregnancy
- Spontaneous termination of pregnancy

Complications of pregnancy do not include:

False labor
Occasional spotting
Physician prescribed rest during the period of pregnancy
Morning sickness
Hyperemesis gravidarum
Pre-eclampsia
Similar conditions associated with the management of a difficult pregnancy not constitution a nosologically distinct complication of pregnancy.

Services and supplies for complications of pregnancy will be covered the same as any other illness or injury.

After your child is born, covered services include:

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

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care provider.

These time frames apply if your child is born without any problem. If your provider tells us that you had a problem during your pregnancy or during childbirth, we will cover the stay the same as we would for any other illness or injury.

Covered services for newborn care include:

Services and supplies needed for circumcision by a provider
Treatment of congenital defects. These services will be covered the same as any other illness or injury

The following are not covered services:

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

Nutritional support

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

Coverage Includes:

Repairing or replacing the original device. Examples of these are:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

Instruction and other services (such as attachment or insertion) so you can properly use the device.

The following are not covered services:

Services covered under any other benefit

Repair and replacement due to loss, misuse, abuse or theft

Osteoporosis

Covered services include services to detect and prevent osteoporosis for:

A postmenopausal woman not receiving estrogen replacement therapy

An individual with:

- Vertebral abnormalities
- Primary hyperparathyroidism
- A history of bone fractures

An individual who is:

- Receiving long-term glucocorticoid therapy
- Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Physician services

Covered services include services by your physician to treat an illness or injury. You can get services:

At the physician's office

In your home

In a hospital

From any other inpatient or outpatient facility

By way of telemedicine or telehealth

Important note:
For behavioral health services, all in-person, covered services with a behavioral health provider are also covered services if you use telemedicine or telehealth instead.

Other services and supplies that your physician may provide:

Allergy testing and allergy injections

Radiological supplies, services, and tests

Immunizations that are not covered as preventive care

The Types of services that require preauthorization section is revised as follows:

A preauthorization may not be required for some services if your provider meets the requirements of prior preauthorization approvals. Please contact your physician or us for additional information.

Your provider may request a renewal of an existing preauthorization within 60 days of the expiration date of the preauthorization. We will notify you of our decision before the expiration of the existing preauthorization.

Partial fill dispensing for certain prescription drugs

We allow a partial fill of your prescription if:

Your pharmacy or prescriber tells us that:

- The quantity requested is to synchronize the dates that the pharmacy fills your prescription drugs
- The synchronization of the dates is in your best interest

You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

Prescription eye drops

You may refill prescription eye drops to treat a chronic eye disease or condition if:

The original prescription states that additional quantities are needed

The refill does not exceed the total quantity of dosage units stated on the original prescription, including refills

The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:

- 21st day after the date a 30-day supply is dispensed
- 42nd day after the date a 60-day supply is dispensed
- 63rd day after the date a 90-day supply is dispensed

Anti-cancer drugs taken by mouth, including chemotherapy drugs

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

Coverage for oral anti-cancer prescription drugs will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a prescription drug benefit. Also, the cost sharing for anti-cancer

The following has been added to or replaced in the *Preventive care* section of your schedule of benefits

Preventive care

Description	In-network	Out-of-network
Preventive care services	0% per visit, no deductible applies	30% per visit after deductible No deductible, copayment or coinsurance applies to immunizations for children through age 6
Breast feeding counseling and support	0% per visit, no deductible applies	30% per visit after deductible
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	0% per visit, no deductible applies	30% per visit after deductible
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	0% per visit, no deductible applies	30% per visit after deductible
Counseling for obesity, healthy diet	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	0% per visit, no deductible applies	30% per visit after deductible
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	0% per visit, no deductible applies	30% per visit after deductible
Counseling for tobacco cessation visJ /FAAAAH 11		

Immunizations	0%, no deductible applies	30% after deductible No deductible, copayment or coinsurance applies to immunizations for children through age 6
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Routine cancer screenings	0% per visit, no deductible applies	30% per visit after deductible
Mammogram limits	One mammogram every year for covered persons 35 and older. When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history Tf [1(dc10.473	

Routine physical exam Routine physical exam limits	0% per visit, no deductible applies Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and	30% per visit after deductible

Inpatient and outpatient treatment for acquired brain injury

Covered services include treatment for an acquired brain injury. An acquired brain injury does not include a congenital or degenerative illness or injury. It means a neurological injury to the brain, after birth, that results in loss of:

- Physical function
- Sensory processing
- Cognition
- Psychological behavior

The therapy is coordinated with us as part of a treatment plan intended to:

- Maintain or restore previous cognitive function
- Slow further loss of function

Covered services include the following therapies related to an acquired brain injury:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment.
- Neurofeedback therapy
- Remediation
- Post-acute transition services
- Community reintegration services
- Post-acute care treatment due to, and related to, an acquired brain injury. If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive.

Covered services also include care in an assisted living facility that is:

- Within scope of their license, and

Telemedicine, teledentistry or telehealth

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

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

The following are not covered services:

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

Teledentistry

A health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Therapies – chemotherapy

Chemotherapy

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

Covered services also include anti-cancer prescription drugs for chemotherapy. Coverage for oral anti-cancer prescription drugs will not be less favorable than for intravenously or injected anti-cancer medication covered as a medical benefit rather than as a prescription drug benefit. Also, the cost-sharing for anti-cancer prescription drugs will not exceed the coinsurance or copayment applicable to a chemotherapy visit or cancer treatment visit. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

The following content is added or replaced in the

Key Terms

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

Plan:

A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

A plan includes:	Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage Individual and group health maintenance organization evidences of coverage Individual accident and health insurance policies Individual and group preferred provider benefit plans and exclusive provider benefit plans Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care Medical care components of individual and group long-term care contracts Limited benefit coverage that is not issued to supplement individual or group in-force policies Uninsured arrangements of group or group-type coverage The medical benefits coverage in automobile insurance contracts Medicare or other governmental benefits as permitted by law
A plan does not include:	Disability income protection coverage The Texas Health Insurance Pool Workers' compensation insurance coverage Hospital confinement indemnity coverage or other fixed indemnity coverage Specified disease coverage Supplemental benefit coverage Specified accident coverage School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis Benefits provided in Long-term care insurance contracts for non-medical

services, for example, personal care,

Allowable expense:
Allowable expense is a health or dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person.

Allowable expense for benefits provided in the form of services:	When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
Expenses that are not allowable expenses:	An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense. Some expenses and services are not allowable expenses. Here are some examples: The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses. If a person is covered by two or more plans that don't have a negotiated charge and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for specific benefit is not an allowable expense. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense. If a person is covered by one plan that does not have negotiated charges and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on negotiated charges, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care

	provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated charge or payment amount that is different that the primary plan's payment arrangement and if the health care provider or physician contract permits, the negotiated charge or payment must be the allowable expense used by the secondary plan to determine its benefits. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and network provider and physician arrangements.

Allowed amount:
Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an out-of-network provider. The amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

Closed panel plan:
Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

Custodial parent:
Custodial parent is the parent with the right to designate the primary residence of a child by court order under

Determining who pays

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

A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan

Child of: Parents, who is also covered under a spouses plan	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.	The plan has covered the person longer is primary If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.

Effect of prior plan coverage

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

Effect on the benefits of this plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:

- Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
- May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
- Must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will f(t to i)-mfd(b)-1(e)1(n)-1(e)1(fi)-1(ts it)-1(w)4m0 0 5d to -1(st

Recovery rights related to workers' compensation

If we pay more than we should have because workers' compensation benefits paid for the same illness or injury

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

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You, someone who represents you, or your provider may file the complaint. You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your

The provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the policy
Requests for step therapy exception

The chart below shows how much time we have to tell you about an adverse determination.

Type of notice	When you need care to make sure you are stable following emergency treatment (post-stabilization)	While you are in the hospital	When not hospitalized at the time of the decision	Prescription drugs or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating provider	Within 1 business day by phone or email to your provider			

Appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The *Appeal of a complain*t and *Appeal of adverse determinations* sections below explain the appeal.

Claim decisions and appeal procedures

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

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

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider in the review your appeal. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee members.
- Texas Health Aetna representatives who were not involved in making the initial decision.
- Providers (including specialists) who were not involved in making the decision. We will us a provider with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:

- A copy of any documentation to be presented by our staff
- The specialties of the physician or providers consulted during the review
- The name and affiliation of all Texas Health Aetna representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at:

  Texas Department of Insurance
  P.O. Box 149104
  Austin, TX 78714-9104
  1-800-252-3439

If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

Appeal of an adverse determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

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

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

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

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

Another person may submit an appeal for you, including a provider. That person is called an authorized

Expedited internal appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a hospital. You can also ask for an expedited internal appeal if we deny a request for step therapy exception or a request for prescription drugs or intravenous infusions you are currently receiving.

Important note:
You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determination

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

Type of claim	Our response time from receipt of appeal
Urgent care claim	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
Emergency medical condition	As soon as possible but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than 1 hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of hospital stays)	No later than 1 business day from the date all information to complete the review is received*
If you are receiving prescription drugs or intravenous infusions	As soon as possible but no later than 1 business day from the date all information to complete the review is received*
Pre-service claim requiring preauthorization	As soon as possible but no later than 15 calendar days*
Requests for step-therapy exception (non-emergency)	No later than 72 hours after we receive the request
Requests for step-therapy exception (emergency)	No later than 24 hours after we receive the request
Acquired brain injury	No later than 3 business after the request
Retrospective claim	As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received

*If your appeal is denied, your provider may ask us in writing to have a certain type of specialty provider review your case. The request must be made no later than 10 business days after the appeal was denied. A provider

Independent review

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

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

How long will it take to get an IRO decision?

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

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

You may be able to get a faster independent review after an adverse determination if:

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

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

The adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hour if your request is for an exigent circumstance.

The following content is added or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate:

Who can be a dependent on this plan

You can enroll the following family members:

Your legal spouse

Your domestic partner who meets policyholder rules and requirements under state law

Dependent children – yours or your spouse's or partner's

- Dependent children must be:
  - Under 26 years of age
- Dependent children include:
  - Natural children
  - Stepchildren
  - Adopted children including any children placed with you for adoption*
  - Foster children
  - Children you are responsible for under a qualified medical support order or court order
  - Grandchildren in your legal custody
  - Grandchild who is your dependent for federal tax purposes at the time application for coverage of the grandchild is made
  - A grandchild whose parent is already covered as a dependent on this plan

*Your adopted child may be enrolled as shown in the *When you can join the plan* section, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

Adding new dependents

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

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

Birth:

- Your newborn child is covered on your health plan for the first 31 days after birth.
  To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the covered dependent.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.

Adoption or placement for adoption:

- A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after you become a party in a suit for adoption or the adoption is complete.
- To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become a party in a suit for adoption or the adoption is complete.
- If you miss this deadline, your adopted child will not have health benefits after the first 31 days.

Marriage

Legal guardianship

Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Stopping coverage

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

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

When will your coverage end

Your coverage under this plan will end if:

This plan is no longer available
You ask to end coverage
The policyholder asks to end coverage
You are no longer eligible for coverage
Your work ends
You stop making required premium contributions, if any apply
We end your coverage for one of the reasons shown in this section
You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

A dependent is no longer eligible for coverage.
You stop making premium contributions, if any apply.
Your coverage ends for any of the reasons listed above except:

- Exhaustion of your overall maximum benefit.
- You enroll under a group Medicare plan we offer.

Your employer will notify Aetna of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

Your employer notifies you at least 30 days before coverage ends
You and your dependents are covered under COBRA or state continuation
You and your dependents are enrolled in another health plan that starts before the end of the month after we receive the notice

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

We will not end your coverage based on your health care status or needs, we also will not end your coverage because you used your rights under the *Complaints, claim decisions, and appeal procedures* section.

Continuation of coverage – State of Texas

Continuation privilege for certain dependents

There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

Qualifying event causing loss of coverage:	Covered persons eligible for continued coverage:	Length of continued coverage (starts from the day you lose current coverage):
Death of employee Retirement of employee Retirement of employee	Dependent who has been covered under the plan for at least one year An infant under one year of age	3 years

When do I receive state continuation information?

The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

Notice	Requirement	Deadline
You or your covered spouse	Send written notice to your employer	Within 15 days of the qualifying event
Your employer	Will provide you with an enrollment form to continue coverage	No later than 15 days after they receive notification
You or your covered spouse	Complete the enrollment form to continue coverage	Within 60 days of the qualifying event.

You must send the completed enrollment form from within 60 day of the qualifying event. If you don't, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

Group continuation privilege

You may continue coverage if your coverage ends for any reason except:

- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:

- Your coverage ends or
- You are given notice by the contract holder

Your first premium payment must be made within 45 days after the date of the coverage election. After that, premium payments are due no later than the end of the grace period after the premium due date.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA

Legal action

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

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

Notice of claim

You must give us written notice of claim within 20 days (or as soon as reasonably possible) after you have incurred expenses for covered services. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Physical examination and evaluations

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

Proof of loss

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

You have special rights if we rescind your coverage:

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

We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the effective date of this certificate.

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made by the end of the grace period. Any decision to not pay benefits can be appealed.

When you are injured by a third party

If a third party caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money for 590008n¥Vt durie

How will Attorney's fees be determined?

If we do not use an attorney:

We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses

If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery

If we use an attorney:

The court will award attorney's fees to our attorney and your attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of our (and any other payors) recovery.

Payor means a plan issuer that:

Has a contractual right of subrogation, and

Pays benefits to you or on your behalf as a result of personal injuries caused by someone else's tortious conduct

A payor includes, but is not limited to, an issuer of:

A health benefit that provides benefits for medical or surgical expenses(t of)d:0

You will need to ask us to make direct payment to the Texas Department of Human Services.

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

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

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

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

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

Important note: The following apply only if you live in Washington. The benefits below will apply instead of those in your booklet-certificate.

Domestic Partners

If your plan includes coverage for dependents, you can also enroll the following family members on your plan.

Your domestic partner and their dependent children

Adding new dependents

If your plan includes coverage for dependents, you can add the following new their dew thnn the

Neurodevelopmental therapy

Eligible health services include rehabilitative and habilitative speech, physical or occupational therapy, but only if it is expected to:

- Restore or improve speech or a body function
- Develop speech or a body function that was lost or delayed because of an illness or because of a condition you had when you were born
- Maintain speech or a body function that would get worse because of an illness or because of a condition you had when you were born

Home health care

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

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

Short-term physical, speech and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home.

Home health care services do not include custodial care.

Exclusions

Your plan does not cover the following under this section:

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

Hospice care

Eligible health services include inpatient and outpatient hospice care when given as part of a hospice care program.

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

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Bereavement counseling
- Respite care

Jaw joint disorder treatment

Eligible health services include the diagnosis and surgical treatment of jaw joint disorder by a provider which includes:

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

The following are not covered under this benefit:

- Non-surgical treatment of jaw joint disorder

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

How can you extend coverage during a strike, lockout or other labor dispute?

You have a right to extend coverage for you and your dependents even if you are absent from work because of a strike, lockout or other labor dispute if:

- You were covered on the date you stopped working, and
- You paid your premium when due

You can continue your coverage for up to 6 months if you pay your premiums to your employer. Your employer will send your payment to Aetna. Call the number on your ID card to get the process started. Your coverage will continue until:

- You go to work full-time for another employer
- You do not make the required premium payments
- The labor dispute ends, or
- The 6 months continuation period ends

Your premium payment will be the same rate you were paying on the date you stopped working. But, if the premium amount your employer has to pay changes during the time you are extending your coverage, your premiums will also change.

Coordination of benefits

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

Key terms

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

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

Any contract that you can obtain or maintain only because of membership in or connection with a

Child of: Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: The plan of the custodial parent pays first The plan of the spouse of the custodial parent (if any) pays second The plan of the noncustodial parents pays next The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See *Child of* content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rule m 164.44999695 0r	

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age
- Disability
- End stage renal disease

When you are enrolled for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid.

Who pays first?

Other health coverage updates – contact information

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

Online: Log on to your Aetna secure member website
By phone: Call the number on your ID card

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

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

Any person we paid or for whom we paid, or
Any other plan that is responsible under these COB rules.

Important note: If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan, you should promptly report to your providers and plans any changes in your coverage.

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

For claims involving out-of-network providers:

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

Types of claims and communicating our claim decisions

You or your provider is required to send us a claim in writing. If you or your dependent goes to a network provider, the network provider will file the claims. When you go to an out-of-network provider, you will have to file the claims. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

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

Urgent care claim

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

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

Pre-service claim

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

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

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

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

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	Within 48 hours or Within 1 business day for an emergency request	5 calendar days	30 calendar days	No later than 24 hours for urgent request* or 5 calendar days for non-urgent request
Request for Extension	Not applicable	Within 5 calendar days	15 calendar days	Not applicable
Additional information request (us)	24 hours	5 calendar days	30 calendar days	Not applicable

Adverse benefit determinations

We pay many claims at the full rate negotiated charge if you go to a network provider and the recognized charge if you go to an out-of-network provider, except for your share of the costs.

But sometimes we may pay only some of the claim. And sometimes we may deny payment or service entirely.

We may sometimes:

- Deny
- Change
- Reduce, or
- Terminate your

Health care services or benefits
Authorization relating to such services or benefits, or
Coverage or payment for the health care services or benefits

Such actions are called “adverse benefit determinations.” Other actions that are also called “adverse benefit determinations” include:

- We do not authorize a stay in a hospital or other facility
- We decide that you or your dependents were not eligible for the coverage when you received the services
- We decide that you have reached your benefit maximums
- Your health care services are excluded, not covered or limited in some way
- We rescind your coverage entirely

Reasons for adverse benefit determinations may be:

The results of utilization review activities
The health care services are experimental or investigational
The health care services are not medically necessary

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Appeals of adverse benefit determinations

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at				

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

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Will accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your provider must call us or send us a Request for External Review Form.

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

For initial adverse determinations

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

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

For final adverse determinations

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

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

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

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a grievance or appeal.

Out-of-network benefits disclosure

Your health plan's out-of-network benefits

Gender

Driving directions

Obtain an estimated range of the out-of-pocket costs for an out-of-network benefit

Contact member services at the number on your ID card for help estimating your out-of-pocket cost for an out-of-network benefit. Out-of-network providers do not have a contracted rate with Aetna. We don't know exactly