

# BENEFIT PLAN

Prepared Exclusively For  
PrideStaff, Inc.

Open Choice PPO HDHP

## Extraterritorial Riders

**Aetna Life Insurance Company**

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



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# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Alabama. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

### Diabetic supplies, drugs, and insulin important note:

Your cost share will not exceed \$100 per 30 day supply of a covered **prescription** insulin drug filled at a network pharmacy. No **deductible** applies for diabetic supplies and insulin.

### Pharmacy

All **prescriptions** and refills over a 30 day supply may be filled at a **retail pharmacy** or a **mail order pharmacy**.

### 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 15 days.

### **Post-service claim**

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

### **Concurrent care claim extension**

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

### **Concurrent care claim reduction or termination**

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

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **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.

Upon receipt of any clean written claim submitted by a **provider**, if **Aetna** fails to provide the necessary claim determination or issue a notice of an extension to the **provider** within the time periods specified above, the amount of the overdue claim, if and when it is determined to be payable, will include an interest payment of 1.5% per month prorated daily which shall accrue from the date the payment was overdue and which will be payable at the time the claims is paid.

### **Filing a claim**

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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We have processes to review claims before and after payment to ensure the services billed meet one or more of the following:

- Our reimbursement policies
- Are free from fraud, waste, and abuse

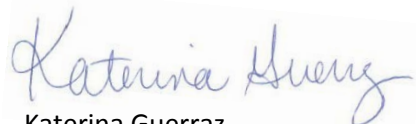
When we review, we will evaluate submitted claim information and determine the accuracy of the procedure and diagnosis codes for the services billed. Sometimes, this review will change how we pay for the services and what we allow on a claim. This doesn't mean that a service isn't a **covered service**. It may mean that the claim should be submitted differently, or the services billed on the claim don't satisfy one of the items above.

We will tell you and your **provider** of our decision if we find any of the items above are not met.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and, appeal procedures* section for that information.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Alabama Medical ET  
Issue Date: November 17, 2025

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### Out of network expenses

If your plan includes in-network and out-of-network benefits, out-of-network benefits will always be provided if network services are covered and will be covered with no more than a 25% cost-sharing difference.

### Advanced reproductive technology (ART)

Advanced reproductive technology, 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).
- Cryopreservation (freezing), storage for up to 5 years and thawing of embryos, eggs, 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.)
- Prescription drugs injected by your provider to stimulate the ovaries

**ART covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan.

For plans with ART cycle limits, an ART “cycle” is defined as:

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

### Aetna's National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility Institutes of Excellence™(IOE) facilities. 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 medical services that are proven to result in infertility such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's infertility clinical policy

### Premature ovarian insufficiency

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

### Infertility services exclusions:

The following are not **covered services**:

- Infertility medication not injected by your **[provider]**, including but not limited to menotropins, hCG, and GnRH agonists. [See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs for your plan
- 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 or other abnormal testing results as outlined in Aetna’s infertility clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.

## Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

### Emergency

**Covered services** include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first can’t provide the **emergency services** you need

**Covered services** also include treatment, triage or transport by a licensed ambulance service if coordinating your care through **telemedicine** with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint if:

- Ambulance service treatment is initiated as a result of a 911 call
- You are treated in place
- You are triaged or triaged and transported to an **alternative destination**; or
- You are treated but decline transport by the ambulance service against medical advice

Includes ambulance service transportation to the treatment location and is subject to plan **deductibles** or **copayment** requirements .

The following are not **covered services**:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

### Diagnostic lab work

**Covered services** include:

- Lab
- Pathology
- Biomarker testing for diagnosis, treatment, appropriate management or ongoing monitoring of cancer

- Other tests

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

## Gastroparesis

**Covered services** include a gastric pacemaker for the treatment of gastroparesis.

## Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

## Prenatal care

**Covered services** include your routine pregnancy physical exams at the **physician, PCP, OB, GYN or OB/GYN** office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B and Hepatitis C screening
- Maternal weight
- Rh incompatibility screening

## 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. Eligible health services are covered regardless of delivery method, whether enteral or oral, or sole source of supplement.

**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 autoimmune neuropsychiatric disorders**

**Covered services** include diagnosis, evaluation and treatment of pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

### **Pharmacy**

All **prescriptions** and refills up to a 90 day supply may be filled at a **retail pharmacy** or a **mail order pharmacy**

### **Physical, occupational and speech therapies**

Any copayment, coinsurance or deductible, or combination of, that applies to services provided by a licensed physical therapist, occupational therapist or speech-language pathologist, will be no greater than any copay, coinsurance or deductible amount that applies to any office visit to a licensed primary care physician or osteopath.

### **Routine physical exams**

A routine 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:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women
  - Screening for depression of the birth mother within 6 weeks of the date of giving birth

**Covered services** include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests

- For covered newborns, an initial **hospital** checkup

## 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, including prosthetic devices for athletics or recreation, and for showering or bathing.

Coverage includes:

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

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

The following are not **covered services**:

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

## Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - Treatment is for a craniofacial disorder such as cleft lip or palate including orthodontic services, dental care, and vision care
  - Treatment is approved by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association in Chapel Hill, NC.
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

**Covered services** also include a dehumidifier every 4 years, as deemed **medically necessary** by your **provider**.

## 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
- Newborn screening for core conditions as recommended by the U.S. Secretary of Health and Human Services

**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

## Telemedicine

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

**Covered services** for **telemedicine** 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 provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- **Telemedicine** kiosks

## External review

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

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

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

- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental or investigational**

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

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

The external review forms are also available on the AID website at [insurance.arkansas.gov](http://insurance.arkansas.gov). You may also contact AID by phone at (501) 371-2640 or (800) 852-5494. A request for the external review forms can be made in writing and sent to the:

Arkansas Insurance Department  
1 Commerce Way, Suite 102  
Little Rock, AR 72202

You must make an oral or written request for external review form:

- To the Arkansas Department of Insurance (AID). You may submit by email to [insurance.consumer@arkansas.gov](mailto:insurance.consumer@arkansas.gov), or fax: (501) 371-2749, or mail to:  
External Review Division  
Arkansas Insurance Department

1 Commerce Way, Suite 102  
Little Rock, AR 72202

- Within 4 months of the date you received notice of the decision from Aetna of an adverse determination or final adverse determination, when you are requesting a standard external review or a standard or expedited review for experimental or investigational treatment
- With a copy of the notice from us, along with any other important information that supports your request

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

We will contact the IRO that will conduct the review of your claim.

The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

### **How long will it take to get an IRO decision?**

The IRO will give us, you and the Arkansas Insurance Department (AID) a 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 an expedited external review decision. You or your authorized representative must call us or send us a request for external review form.

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

#### **For initial adverse benefit determinations**

- Your **provider** tells us a delay in 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)

#### **For final adverse determinations**

Your **provider** tells us a delay in 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.

### **Timeframes for external review decisions**

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

<b>Type of external review</b>	<b>When we complete a preliminary review of the request and notify you</b>	<b>When the review request is assigned to the IRO</b>	<b>When the IRO completes their review and notifies you</b>
Standard external review	Within 1 business day after the date of receipt of the notice	Within 1 business day after receiving notice from Aetna, the Arkansas Insurance Department will assign an IRO	Within 45 days after the date of receipt of the request to complete the review
Expedited external review (oral or written)	Within 1 business day after the date of receipt of the notice	Immediately after receiving request from Aetna, the Arkansas Insurance Department will assign an IRO	As soon as possible but no longer than 72 hours after getting assigned after the date of the receipt of the request to complete the review, or within 48 hour of the oral notice
Standard external review of experimental or investigational treatment adverse determination	Within 1 business day after the date of receipt of the notice	Within 1 business day after receiving notice from Aetna, the Arkansas Insurance Department will assign an IRO	Within 45 days after the date of receipt of the request to complete the review
Expedited review of experimental or investigational treatment adverse determination	Within 1 business day after the date of receipt of the notice	Immediately after receiving request from Aetna, the Arkansas Insurance Department will assign an IRO	As soon as possible but no longer than 72 hours after getting assigned after the date of the receipt of the request to complete the review, or within 48 hour of the oral notice

## **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
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 90 days after the event birth of your newborn, 60 days after the petition for adoption is filed or from the moment of birth, and 31 days after the event date for all other events.

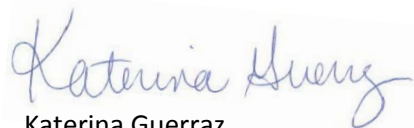
**How you can extend coverage when getting inpatient care when coverage ends**

Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

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

- When you are discharged
- When you no longer need inpatient care
- Exhaustion of benefits
- When you become covered by another health benefits plan

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Arkansas Medical ET

Issue Date: November 17, 2025

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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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

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## Complaints, claim decisions and, appeal procedures

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### 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

The appeal process information packet explains all of your appeal rights. We sent you a copy of this. If you need another copy you can obtain one by contacting us. When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### 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 your member 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.

## External review

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

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

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

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

## IRO decisions

The IRO will make a decision and notify the Insurance Director. The Insurance Director will notify us, you and your **provider**.

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

## Utilization review

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits

- Requiring a partial fill or denial of coverage

## 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.

## Primary care provider (PCP)

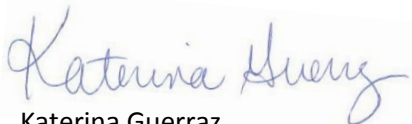
A **provider** who:

- The directory lists as a **PCP**
- Is selected by you from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to you
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Nurse practitioner
- Physician assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group, primary care office, or another **provider** allowed by the plan
- Chiropractors

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Arizona Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 unless the benefits in your booklet-certificate are better.

### Cleft Palate and Cleft Lip Conditions

**Covered 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

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial if all of the following conditions are met:

- Your **physician** recommends participation in the clinical trial because it has the potential to provide a therapeutic health benefit to you
- The trial is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended
- Your care is provided by a certified, registered, or licensed [**provider**] working within the scope of their practice
- Your treatment is provided in a facility and by personnel who have the proper experience and training
- Prior to participation in a clinical trial, you sign a statement of consent indicating that you have been informed of the procedure, alternative methods of treatment and the associated risks
- Your condition is disabling, progressive, or life-threatening

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, provided as part of an active individualized family service plan, that enhance functional ability without affecting cure. They include, but are not limited to:

- Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury
- Occupational or physical therapy for a body function impaired by a congenital abnormality, disease or injury

#### **Covered services:**

- Are available to an eligible child from birth up to the child’s third birthday.
- Must be performed by a qualified early intervention service **provider** listed in the applicable registry. Contact the Colorado Department of Human Services, Division of Community and Family Support Health Department for eligibility requirements and benefit limits.

Coverage for early intervention services for covered children supplements, rather than duplicates or replaces, treatment for Autism spectrum disorder. The early intervention services annual benefit limit will not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation.

### **Maternity and related newborn care**

**Covered services** include pregnancy (prenatal) care, **complications of pregnancy** care, care after delivery and obstetrical services including maternity support services provided by a doula before, during, and after childbirth.

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**

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 such as:

- Maternal PKU
- Maple Syrup Urine Disease
- Tyrosinemia
- Homocystinuria
- Histidinemia
- Urea cycle disorders
- Hyperlysinemia
- Glutaric Acidemias
- Methylmalonic Acidemia
- Propionic Acidemia
- Immunoglobulin E and nonimmunoglobulin e-mediated allergies to multiple food proteins
- Severe food protein induced enterocolitis syndrome
- Eosinophilic disorders as evidenced by the results of a biopsy
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract

The following are not **covered services**:

Any food item, including:

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

## **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

Covered services also include additional prosthetic devices for physical and recreational activity that your **physician** orders and determines necessary.

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

The following are not **covered services**:

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

## 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
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible

**Complications of pregnancy** do not include conditions associated with the management of a difficult pregnancy such as:

- False labor
- Occasional spotting
- Morning sickness
- **Physician** prescribed rest during pregnancy
- Hyperemesis gravidarum
- Pre-eclampsia

## Telemedicine

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

**Covered services** for **telemedicine** 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 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** kiosks
- Electronic vital signs monitoring or exchanges (e.g., Tele-ICU, Tele-stroke)

## 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, OB/GYN or other health professional for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

## 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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### Any other claim appeal

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 contacting us. You need to include:

- Your name
- The plan sponsor's name
- A copy of the adverse benefit 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.

If you are still not satisfied with the answer, you may make a second internal appeal. The second level of internal appeal is at your option. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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.

### Voluntary second level appeal

If you disagree with the first level appeal decision, you can choose a voluntary second level appeal or an external review, if applicable.

The second level appeal will be reviewed by a panel of health care professionals with appropriate expertise who:

- Were not involved in the appeal
- Do not have a direct financial interest in the case or the outcome of the review

You may:

- Attend the second level appeal review.
- Present your case to the review panel in person or in writing.
- Submit supporting material both before, and at, the review meeting.
- Request a copy of the materials that we plan to present at the review at least 5 days prior to the meeting. We will give you any new material developed after the 5 day deadline as soon as possible. We will provide you with all relevant information that is not confidential or privileged under state or federal law.
- Present written comments, documents, records and other materials for the panel to consider both before and at the review meeting. You should provide a copy of your materials to us at least 5 days prior to the date of the meeting. You should give us any new materials developed after the 5 day deadline as soon as possible.
- Ask our representatives any questions prior to the review meeting and ask questions of any panelist at the meeting.
- Choose to have counsel, advocates and health care professionals assist or represent you.

The review panel will schedule and hold a meeting within 60 calendar days of our receipt of your request for a second level appeal review. If you request to appear in person before the panel, the review meeting will be held during regular business hours at a location reasonably close to you, including accommodations for disabilities. We will not discourage you from requesting an in-person meeting. However, in cases where an in-person meeting is not practical, we will offer you the opportunity to communicate with the review panel (at our expense) by conference call, video conferencing, or other appropriate technology. You will be notified in writing at least 20 calendar days in advance of the review date.

After private deliberation, the review panel will issue a written decision to you within 7 calendar days on the conclusion of the review meeting. The decision will contain:

- The names, titles, and credentials of the member of the review panel
- A statement of the panel's understanding of the nature of the appeal and the material facts, including issues you raised
- The rationale for the panel's decision
- References to evidence or documentation considered by the panel in making the decision
- In the case of adverse benefit determinations, instructions for requesting a written statement of the clinical rationale, including clinical review criteria used to make the determination
- An explanation of any further rights available under the medical plan that you have regarding the appeal
- Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to you, if any
- Notice of your right to request an independent external review

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.

### **How you can extend coverage for your child in college on medical leave**

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins
- The date coverage would otherwise end.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury,
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to serious illness or injury.

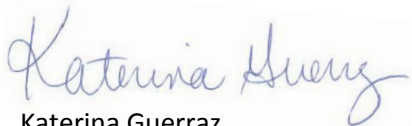
The **physician** treating your child will be asked to keep us informed of any changes.

### **Continuation of coverage – reduction in hours of work**

If you are a full-time employee working 40 or more hours per week, the policyholder may elect to continue coverage for you and your dependents, with us or another insurer, under the same conditions and premiums. This continuation in coverage can occur even if your employer reduces your working hours to less than 30 hours per week if the following conditions are met:

- You are employed as a full-time employee and are covered under the plan, or another plan immediately prior to the reduction in working hours
- Your employer has reduced working hours due to economic conditions or the reduction of hours is due to your injury, disability or chronic health conditions
- Your employer intends to restore you to a full 40-hour per week work schedule as soon as economic conditions improve or as soon as you are able to return to full-time work

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Colorado Medical ET

Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 unless the benefits in your booklet-certificate are better.

### Telemedicine

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

**Covered services** for **telemedicine** 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 provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

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

### Precertification covered services reduction

This only applies to **out-of-network covered services**:

Your certificate contains a complete description of the **precertification** process. You will find details in the *How your plans works - Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it can result in the following benefit reductions:

- **Covered services** reduced by the lesser of 50% of the benefit that would have been payable and \$500

You may have to pay an additional portion of the **allowable amount** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

### Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You 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** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles, copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- If urgent crisis center services were rendered to an insured at an out-of-network urgent crisis center, the urgent crisis center may bill the health carrier directly for such urgent crisis center services. The health carrier shall reimburse such out-of-network urgent crisis center or insured, as applicable, for such urgent crisis center services at the in-network rate under the insured's health care plan as payment in full, unless such health carrier and urgent crisis center agree otherwise.
- Non-emergency surgical services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them. If the out-of-network health care provider and carrier does not notify you of the network status, then you will not pay more than the in-network cost-sharing.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting.

This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in state law or federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

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

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

## **How COB works with Medicare**

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

When you are covered under Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

## **Complaints, claim decisions and appeal procedures**

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### **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**

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### **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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

### **Appeal of an adverse benefit determination**

#### **Urgent care claim**

An urgent claim is one for which the physician treating you decides that 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. **Substance related disorder**, co-occurring **mental health disorder** or a **mental health disorder** requiring hospitalization including inpatient residential treatment, and intensive outpatient services necessary to prevent an inpatient hospitalization are also urgent claims. We will make a decision within 24 hours for **mental health disorders** or **substance related disorders**.

### **Any other claim appeal**

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 contacting us. You need to include:

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

We will assign your appeal to a clinical peer, someone who was not involved in making the original decision. A clinical peer is a **provider** experienced in your medical condition that is under review. For review of adult or child/adolescent **substance related disorder** or **mental health disorder** the **provider** must hold:

- A national board certification in (child and adolescent or adult, as applicable) psychiatry or
- A doctoral level psychology degree with training and clinical experience in the treatment of (child and adolescent or adult, as applicable) **substance related disorder** or child and adolescent **mental health disorder**

You will receive a decision within 30 calendar days for a post-service claim.

Each nonurgent prospective or concurrent review request will be acknowledged not later than 24 hours after the request was received, unless required by federal law.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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.

### **Timeframes for deciding appeals**

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

Claim type	Decision timeframe	Extensions
Urgent care claim For mental health disorder or substance abuse appeals	36 hours 24 hours	None
Pre-service claim	15 days	None
Post-service claim	30 days	Non-urgent care request: one time 15 calendar day extension
Concurrent care claim	As appropriate to type of claim	5 days or 15 days if the service will not occur for at least 3 months from when we received the request

## 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 Connecticut Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Connecticut 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, a **mental health disorder** or **substance related disorder** claim or a 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 Connecticut. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

- You may contact the Connecticut Department of Insurance for assistance regarding any complaint, grievance or appeal at the following address:

State of Connecticut Insurance Department

Consumer Affairs Department

P.O. Box 816

Hartford, CT 06142-0816

860-297-3900 or 800-203-3447

[cid.ca@ct.gov](mailto:cid.ca@ct.gov)

- You may also contact the Office of Healthcare Advocate at:

State of Connecticut

Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06144

866-297-3992

[Healthcare.advocate@ct.gov](mailto:Healthcare.advocate@ct.gov)

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental or investigational**

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

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

You must submit the request for external review form:

- To the Connecticut Insurance Department
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will need to mail your application for External Review to:

Connecticut Insurance Department  
Attention: External Review  
P.O. Box 816  
Hartford, CT 06142-0816

- If you are using an overnight delivery service, mail to:  
Connecticut Insurance Department  
Attention: External Review  
153 Market Street, 7<sup>th</sup> floor  
Hartford, CT 06103

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 Connecticut Department of Insurance will forward the appeal to **Aetna** and **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 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 ability to regain maximum function
  - 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 a delay in 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 36 hours of us getting your request.

### **Utilization review**

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

### **Recordkeeping**

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

### **Fees and expenses**

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

We will pay for information we send to the ERO plus the cost of the review.

### **Continuation of coverage for other reasons**

#### **How you can extend coverage if you are totally disabled when coverage ends**

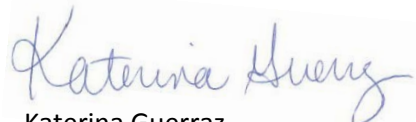
Your coverage may be extended if you are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension. You are “totally disabled” if you cannot work at your occupation or any other occupation for pay or profit.

Your covered dependent is “totally disabled” if they can’t engage in most normal activities like a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

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

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

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Connecticut Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

**Covered services** also include:

- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care
- Items and equipment necessary to provide receive, or improve upon any of the above listed services, including those necessary for Applied Behavior Analysis.
- Any care for Autism spectrum disorder that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be medically necessary.

### 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, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

## 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**.
- 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**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**,] or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease

- Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support specialist(including **telemedicine** consultation)

**Behavioral health important note:**

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**

**Birth center and physician services**

A birthing center is a freestanding facility specifically licensed by state and federal laws to provide pregnancy care, delivery and immediate care after delivery.

**Covered services** include pregnancy and after delivery care from your birthing center **provider**. After delivery, this also includes:

- No less than 48 hours of care after a vaginal delivery
- No less than 96 hours of care after a cesarean delivery

**Covered services** also include charges made by:

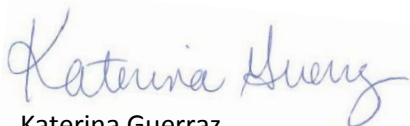
- An operating **physician** or midwife for:
  - Delivery
  - Pregnancy and after delivery care
  - Administration of an anesthetic
- A **physician** for administering an anesthetic (other than a local anesthetic)

**Well woman preventive visits**

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

- Office visit to a **physician, PCP, OB, GYN or OB/GYN** for services including Pap smears
- Ovarian cancer monitoring and screening tests for women at risk for ovarian cancer, as ordered or provided by your **physician, PCP, OB, GYN or OB/GYN**
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

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



Katerina Guerraz  
 Executive Vice President, Chief Operating Officer  
 Aetna Life Insurance Company  
 (A Stock Company)

Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

---

**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

## THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

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

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

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

### 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

### Dental care anesthesia

**Covered services** include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

### **Jaw joint disorder treatment**

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

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

The following are not **covered services**:

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

### **Who can be a dependent on this plan**

- Dependent children – yours or your spouse’s or partner’s
  - A dependent child who is under 26 years of age will be covered until the end of the calendar year after they have reached age 26 provided they meet all of the following:
    - Attending school regularly (full-time or part-time) or living in your household
    - Solely dependent upon you for support
  - A dependent child from the end of the calendar year in which the child turns age 26 until the end of the calendar year in which the child turns age 30, provided the child is:
    - Unmarried and does not have a dependent of their own
    - A resident of Florida or a full-time or part-time student
    - Not eligible for Medicare and not covered under another group, blanket, franchise or individual health benefit plan

### **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
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

A newborn child of a covered dependent other than your spouse, domestic partner, civil union partner is covered for 18 months. At the end of 18 months, coverage for the newborn will be terminated

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

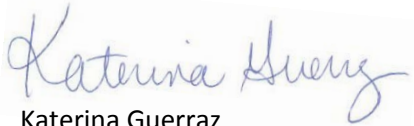
### **Why would we end your coverage?**

Your coverage may end if you act in a way that prevents you from having a good relationship with a **network provider**. We may also end your coverage if you act in a way that affects our business operations. We will give you 45 days notice in writing if we end your coverage for any of these reasons.

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

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

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

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style with a light blue background behind it.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Florida Medical ET  
Issue Date: November 17, 2025

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

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

---

**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Dental care anesthesia

**Covered services** include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate

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

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

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

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

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

**Important note:**

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

## Filing a claim

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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay a written claim within 30 days and an electronic claim within 15 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

## Complaints, claim decisions and appeal procedures

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### 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

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### 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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

## 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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### Any other claim appeal

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 contacting us. 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

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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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 Georgia Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Georgia 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 Georgia. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you

- The violation was for a good cause or beyond our control
- The violation was part of an ongoing, good faith exchange between you and us

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

You must submit the request for external review form:

- To the Georgia Department of Insurance
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The state 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 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 ability to regain maximum function
  - 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 a delay in 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.

### Utilization review

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

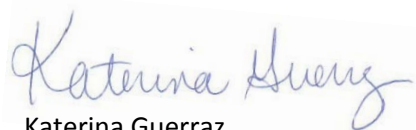
### Recordkeeping

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.



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Georgia Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

You must submit the request for external review form:

- To the Iowa Insurance Division
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Iowa Insurance Division will contact the IRO that will conduct the review of your claim.

The IRO will:

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

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

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 ability to regain maximum function
  - 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 a delay in 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.

**Adding new dependents**

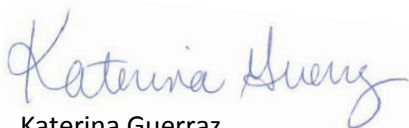
You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

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

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 60 days after the event date.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company

(A Stock Company)

Amendment: Iowa Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs 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.

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 cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- It is determined you may benefit from the treatment

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

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

## General plan exclusions

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The following are not **covered services** under your plan:

### Abortion

Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger

### Abortion drugs

Drugs used for elective termination of pregnancy except when the pregnancy places the woman's life in serious danger

### Filing a claim

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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay a paper claim within 45 days and an electronic claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and, appeal procedures* section for that information.

## Your right to an independent external review

Please read this section carefully. It describes a procedure called independent external review. This allows for review of a disputed health claim by a qualified professional from an organization outside Aetna. This is called an independent review organization (IRO).

If you request an independent external review of your claim, the decision made by the IRO will be binding and final to us. This means that we will stand by the decision that the IRO makes. If your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you will have the right to further review of your claim. This further review would be done by a court, arbitrator, mediator or other dispute resolution entity. If your plan is not subject to ERISA, you do not have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity. This is fully explained below under “Binding nature of the external review decision.”

You may have the right to have our decision reviewed by an IRO if we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply. You have this right only if our denial of your health care service or supply is based on any of the following:

- **Medical necessity**
- Appropriateness
- Health care setting
- Level of care
- Effectiveness
- We determine it was **experimental or investigational**

You must first exhaust our internal appeal process. This is explained in the *Exhaustion of appeals process* section.

Your external review request must be submitted in writing to the Idaho Department of Insurance (DOI):

Idaho Department of insurance  
Attn: External Review  
700 W. State St., 3<sup>rd</sup> Floor  
Boise, ID 83720-0043

For more information and for an external review request form, you can log onto the Idaho DOI website at [www.doi.idaho.gov](http://www.doi.idaho.gov), or call the Idaho DOI at (208) 334-4250 or (800) 721-3272.

You may represent yourself in the request. But you may also name another person, including your **provider**, to represent you. This person is called your authorized representative. If you want someone else to represent you, you must include a signed “Appointment of an Authorized Representative” form with your request.

The IRO may need to review your medical records to make a decision. You must include a completed form authorizing the release of any necessary medical records with your external review request form. If this form is not submitted, the DOI will not act on your external review request.

If your request qualifies for external review, our final Adverse Benefit Determination will be reviewed by an IRO selected by the DOI. We will pay for any information we send to the IRO plus the cost of the review. There are two types of external review requests. They are explained below.

### Standard external review request

You must file the written external review request with the DOI within 4 months after the date we issue a final notice of denial.

- Once the DOI receives your request, they have 7 days to send a copy to us.
- Once we receive your request, we have 14 days to complete a preliminary review. We will notify you and the DOI in writing within 5 business days after completing our preliminary review if additional information is needed or if your request is eligible for external review. If we deny your eligibility for review, you may appeal that decision to the DOI.
- If your request is eligible for review, the DOI has 7 days from the date they receive our notice to assign an IRO to your review. The DOI will also notify you in writing.
- Once you receive this notice from the DOI, you have 7 days to submit any additional information you would like the IRO to review. This information must be submitted in writing.
- The IRO has 42 days after they receive your review request to make a decision. The IRO must notify you, us, and the DOI of that decision.

### **Expedited external review request**

You may file a written “urgent care request” with the DOI for an expedited external review of a pre-service or concurrent service denial. This means that you can have your claim reviewed internally and through the external review process at the same time. An “urgent care request” means a claim relating to any of the following:

- An admission
- Availability of care
- Continued **stay** or health care service for which you received emergency services. This applies if you have not been discharged from a facility
- Any pre-service or concurrent care claim for medical care or treatment for which a decision needs to be made sooner than the timeframe for a standard external review request. This means that waiting for the standard review could:
  - Seriously jeopardize your life or health, or your ability to regain maximum function
  - In your **provider’s** opinion, subject you to severe pain that cannot be adequately managed without the disputed care or treatment
  - Delay treatment so that it would be significantly less effective than if it had started sooner

The DOI will send your request to us. We have 2 full business days to determine if your request is eligible for review. We then have 1 more business day to notify you and the DOI if your request is eligible. If we deny your eligibility for review, you may appeal that decision to the DOI.

If your request is eligible for review, the DOI will assign an IRO and notify you. The IRO has 72 hours after they receive your review request to make a decision, and to notify you, us, and the DOI of that decision. The IRO has another 48 hours to notify you, us, and the DOI of the decision in writing. If the decision reverses our denial, we will notify you and the DOI of our intent to pay the **covered service** as soon as reasonably practicable. This will always be within 1 business day after receiving notice of the decision.

### **Binding nature of the external review decision**

If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the decision made by the IRO will be final and binding on us. This means that we will stand by the decision that the IRO makes. But, you may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the decision made by the IRO will be final and binding on both you and us. This means that both you and we will have to stand by the decision that the IRO makes. You will not have any further opportunity for review of our denial after the IRO makes its final decision. If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration, or filing an action in court.

Under Idaho law, action cannot be taken against the IRO because of its decision or anything they have done in the decision making process, unless those actions were in bad faith or involved gross negligence.

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

### **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
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 60 days after the event date.

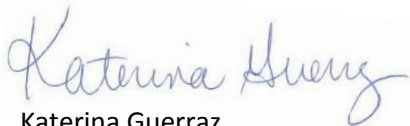
### **How you can extend coverage for maternity benefits**

Your coverage may be extended if you or your dependent is pregnant when coverage ends. Only prenatal and maternity benefits are covered during your extension.

You may extend coverage only for services and supplies related to pregnancy until the earliest of:

- When you become covered by another health benefit plan
- 12 months of coverage

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Idaho Medical ET  
Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Entire Contract

This policy, including the application and any amendments or inserts, constitute your entire policy. A change to the policy is not valid unless approved by an executive officer of Aetna Life Insurance Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

**WARNING: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED.**

YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), non-participating providers furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating provider, plan benefit payments will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. Participating providers have agreed to ONLY bill members the cost-sharing amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

### Routine cancer screenings

**Covered services** include the following routine cancer screenings:

- Low dose mammography screening, for women age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
  - For women 35-39, a baseline mammogram
  - For women 40 years of age and older, annually
  - For women under 40, with a family or prior personal history of breast cancer, positive genetic testing, or other risk factors, at necessary age and intervals
  - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogenous or dense breast tissue, as determined by your **physician**

- Screening MRI, as determined by your **physician**
- Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your **Physician**. This includes individuals who are:
  - Asymptomatic individual age 50 and older
  - Individual men age 40 and over
  - Individual age 40 and over with family history of prostate cancer
  - Colorectal cancer screening
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, and a follow-up exam based on an initial screening.
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Sigmoidoscopies
- Pancreatic cancer screening when medically necessary
- Home saliva cancer screening if they:
  - Are asymptomatic and at high risk for the disease being tested for; or
  - Demonstrate symptoms of the disease being tested for at a physical exam

## Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema or implant removal
  - Protheseses
  - A physician office visit or in-home nurse visit within 48 hours after discharge

**Covered services** also include **medically necessary** breast reduction **surgery**.

### Filing a claim

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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim immediately from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than \$1 may not be paid.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and appeal procedures* section for that information.

## Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “plan” through which you may have other coverage for health care expenses we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

### How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

### 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	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent

<b>COB rule</b>	<b>Primary plan</b>	<b>Secondary plan</b>
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> <li>• Plan of parent responsible for health coverage in court order</li> <li>• Birthday rule applies if both parents are responsible or have joint custody in court order</li> <li>• Custodial parent’s plan if there is no court order</li> </ul>	<ul style="list-style-type: none"> <li>• Plan of other parent</li> <li>• Birthday rule applies (later in the year)</li> <li>• Non-custodial parent’s plan</li> </ul>
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

**How COB works with Medicare**

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

You are eligible for Medicare if you are covered under it.

**Effect of prior plan coverage**

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

**Other health coverage updates – contact information**

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

**Other Insurance in this Company**

Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies.

**Our rights**

We have the right to:

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

## Complaints, claim decisions and, appeal procedures

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### 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. When a complaint is received from the Illinois Department of Insurance, we will respond within 21 days of receiving the complaint.

You may contact the Illinois Department of Insurance at any time. However, you are encouraged to contact us before filing a complaint with the Illinois Office of Consumer Health Insurance. Complaints to the Office of Consumer Health Insurance may be submitted in the following ways:

- Online at <https://mc.insurance.illinois.gov/messagecenter.nsf>
- By email at [consumer\\_complaints@ins.state.il.us](mailto:consumer_complaints@ins.state.il.us)
- By fax to (217) 558-2083
- Office of Consumer Health Insurance hotline telephone number: (866) 445-5364
- By mail to:  
Office of Consumer Health Insurance  
320 W. Washington Street  
Springfield, IL 62767

#### Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### 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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

### 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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

#### Any other claim appeal

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

The deadline for filing an appeal will not be postponed or delayed by a **provider** appeal unless the **provider** is acting as your authorized representative.

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

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

You may also contact Aetna at the following address and telephone numbers:

Aetna

(ISM) CRT

P.O. Box 14002

Lexington, KY 40512

Toll-free telephone number: (877) 204-9186

Fax: (859) 425-3379

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 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 your member website or by contacting us. The form will tell you where to send it to us.

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**

You are encouraged to complete the appeal process with us before you can take these other actions:

- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Illinois Department of Insurance
- Appeal through an external review process
- Pursue non-binding arbitration, litigation or other type of administrative proceeding
- 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.
- You filed an appeal under the internal appeal process and we did not provide a written decision within:
  - 30 days from the date you filed an appeal of a concurrent or pre-service claim
  - 60 days from the date you filed an appeal of a post-service claim except to the extent you agreed to a delay
- You filed a request for an expedited internal review and we did not provide a decision within 48 hours, except to the extent you requested or agreed to a delay

- Your **provider** certifies in writing that the recommended health care service or treatment is **experimental or investigational** and would be significantly less effective if delayed
- We did not follow all of the claim determination and appeal requirements of Illinois Department of Health and Human Services. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

### **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:

- The expiration of 2 years from the date continuation coverage began
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

To request extension of coverage, the dependent, or their representative, can contact us.

### **How you can extend coverage for your former spouse if you die or retire (spousal continuation privilege)**

You have the right to extend coverage for your spouse if coverage would end because:

- Your marriage ends
- You retired or died

To extend coverage, your former spouse must:

- Apply for continuation of coverage
- Pay the required **premium** within 30 days of the date they receive notice of the right to continue

If your former spouse is under age 55, the right to continue coverage will be extended until the earliest to happen:

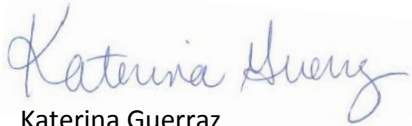
- **2 years** from the date continuation started
- The date coverage starts under another plan
- The date coverage would otherwise end if the marriage had not ended. This will not apply for the first 120 days following the end of the marriage or your death unless the plan ends due to a change in the plan
- The date the spouse remarries
- The date premiums are not paid

If your former spouse is age 55 or older, the right to coverage will be extended until the earlier to happen:

- The date coverage starts under another plan
- The date coverage would otherwise end if your marriage didn't end, you didn't retire or die. This will not apply for the first 120 days following the end of the marriage, your retirement or your death unless the plan ends due to a change in the plan
- The date the spouse remarries
- The date **premiums** are not paid
- The date they reach the qualifying Medicare age or establish Medicare eligibility

The right to continue coverage also includes dependent children whose coverage began prior to the end of the marriage or death.

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

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Illinois Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Indiana. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Questions regarding your policy coverage should be directed to Aetna by calling the toll-free number on your ID card

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street  
Suite 300  
Indianapolis, IN 46204  
Consumer Hotline: (800)-622-4461 or (317)-232-2395  
Complaints can be filed electronically at <https://www.in.gov/doi>

### Routine cancer screenings

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
  - If you are either:
    - Younger than age 45, but considered to be at high risk
    - Age 45 or older
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
  - One mammogram if you are age 35 through 39
  - One mammogram per year if you are either:

- Younger than age 40, but considered to be at risk
- Age 40 or older
- Prostate specific antigen (PSA) tests
  - Younger than age 50, but considered to be at high risk
  - Age 50 or older
- Sigmoidoscopies

### Filing a claim

We will pay the claim immediately when we receive all the information necessary, no later than 30 days if the claim is filed electronically or 45 days if the claim is filed on paper. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Recission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

## Grievances and appeals

### A grievance

You may not be happy about a **provider**, an operational issue, or an adverse benefit determination and you may want to complain. You can contact us at any time.

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

- Your name
- The plan sponsor's name
- A copy of the adverse benefit determination, if you have one
- Your reasons for making the appeal
- Any other information you would like us to consider

After we have received your grievance, we will:

- Let you know within 3 business days
- Review all the information, and let you know if we need anything more
- Respond in writing with our decision as soon as possible, but within 20 days

If we are not able to make a decision within 20 business days, we will:

- Notify you of a delay in writing before the end of the 20 days
- Respond in writing with our decision within 10 more business days

When our review is completed, we will notify you of our decision in writing within 5 business days. Our notification will include the following:

- Our decision
- The reasons for the decision, including our policies and procedures
- Notice of your right to appeal the decision
- The address and telephone number you may contact to obtain additional information about the decision or the right to appeal

Another person may submit a grievance 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.

## **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.

### **Appeals of grievances**

You can appeal our grievance decision on an adverse benefit determination. You can appeal two times under this plan. You must file an appeal within 60 calendar days from the time you receive the notice of grievance decision.

After we have received your grievance, we will:

- Let you know within 3 business days
- Assign your appeal to someone who was not involved in making the original decision
- Respond in writing with our decision as soon as possible, but within 45 days

There may be special reasons why we are not able to make a decision within 45 days. If that happens, we will:

- Notify you of the delay in writing before the end of the 45 days
- Explain why we need an extension and when you can expect a decision
- Respond with our decision within 45 more days

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.

When our review is completed, we will notify you of our decision in writing within 5 business days. Our notification will include the following:

- Our decision
- The reasons for the decision, including our policies and procedures
- Notice of the right to other remedies allowed by law, including external review
- The address and telephone number you may contact to obtain additional information about the decision or the right to appeal

## **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
  - Dependent children must be:
    - Under 26 years of age

### **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.

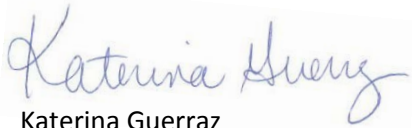
Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption, whichever is earlier

- Marriage
- Legal guardianship
- Court or administrative order

Your newborn child is covered for the first 31 days after birth. To keep your newborn covered, we must receive your completed enrollment information and premium contribution for the covered dependent within 31 days of birth.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Indiana Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

---

**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a **provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs 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.

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 cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- You have been diagnosed with cancer and accepted into a phase I, Phase II, Phase III or phase IV clinical trial for cancer
- Your treating **physician** determines that you may benefit from the treatment

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

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

## Dental care anesthesia

**Covered services** include general anesthesia and facility charges for dental care only if you:

- Have a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided
- Are severely disabled, or
- Are under 6 years old

## Maternity and related newborn care

**Covered services** include pregnancy (prenatal) care, care after delivery and obstetrical services, including obstetrical services for the birth mother of a child you adopt within 90 days of birth. 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

## Off-label use

**Covered services** may include off-label use of FDA-approved **prescription drugs** when it is not approved for your condition, including cancer. Eligibility for coverage is subject to the following:

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

### **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. We pay oral anti-cancer drugs the same as intravenous (IV) anti-cancer drugs.

The following is not a **covered service** under your plan:

### **Abortion**

Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger.

### **Work related illness or injuries**

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

### **External review**

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**
- You have exhausted all available internal review procedures, unless
  - You have an **emergency medical condition**
  - You have not received a final adverse decision from us within 60 days of your request, unless the delay was requested by you, or
  - We have not strictly followed the appeal procedure requirements according to state or federal law

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

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

You must submit the request for external review form:

- To the Kansas Insurance Department at 1300 SW Arrowhead Rd., Topeka, KS 66604
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Kansas Insurance Department 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 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 30 business 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?**

The ERO will give you their decision not more than 30 business days after the ERO receives 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 ability to regain maximum function
  - 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 a delay in 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 your request from the ERO, or as quickly as your medical condition or circumstances require.

### **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
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date. For birth, adoption or placement for adoption, we must receive a completed enrollment form not more than 31

days after the event date if additional premium for the covered dependent is required

### **Continuation of coverage - State of Kansas**

If your circumstances are not covered under federal law and you and your dependents' coverage terminates with us for any reason, you may continue your coverage if the following conditions are met:

- Premium payments are continued
- Coverage has been maintained for at least 3 months
- Written request is made for continuation within 31 days after this coverage would have terminated
- Coverage is not terminated for cause
- Coverage is not replaced by similar group coverage within 31 days
- Medicare or other group coverage is not available

Coverage ends at the earliest of:

- The end of the 18 month period following termination
- The premium is not paid

If coverage continues for the 18 month period, conversion to an individual health plan will be available to you.

### **How you can obtain other coverage after your group coverage ends**

When your group health plan ends, you may be eligible to apply for comprehensive guaranteed issue coverage through an individual policy inside or outside the Health Insurance Marketplace:

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

Application and payment of the initial premium for such individual policy should be consistent with the terms described in the respective policy chosen by you. Contact us to learn about other insurance coverage options available to you.

### **Converting from a group to an individual health plan**

When your group health plan ends, you may be eligible to change to an individual health plan.

### **When are you eligible for a conversion plan?**

You are eligible if:

- You had group health coverage under this plan continuously for the last 3 consecutive months before your coverage ended, and
- Your COBRA coverage has ended and you aren't eligible for additional extensions

You are not eligible if:

- You did not pay your premium contributions under this plan.
- This plan ends because the contract between the group and us ends and is replaced by another group plan within 31 days.
- You are eligible for health coverage under another group plan.
- You are eligible for Medicare coverage, whether or not you have actually enrolled in Medicare.
- You are already covered under an individual health plan.

## How you apply for a conversion plan

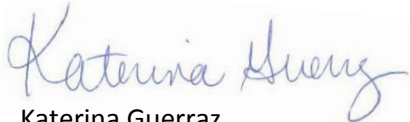
To apply:

- We must receive your application and your first premium payment within 45 days after your group plan ends.

## Telemedicine

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

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



Katerina Guerraz

Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Kansas Medical ET

Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

---

**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Kentucky. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Cochlear implants

**Covered services** include cochlear implants if you are diagnosed with profound hearing impairment.

### 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.

For the purpose of this benefit, “amino acid modified preparation” means a product intended to be used under the direction of a **physician** for the dietary treatment of an inherited metabolic disease.

**Covered services** include amino acid modified preparation 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 human milk fortifiers or 100% human milk-based diet when prescribed for the prevention of Necrotizing Enterocolitis. A **physician** must prescribe and provide direction for administration.

The following are not **covered services**:

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items

### Prescription eye drops

We will cover an extra supply for prescription eye drops when the original prescription indicates that an additional bottle is needed for use in a day care center or school.

## Routine cancer screenings

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
- Genetic test for cancer risk consistent with the guidelines published by the National Comprehensive Cancer Network (NCCN)

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

## Telehealth

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

**Covered services** for **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 **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
- **Telehealth** kiosks
- Electronic vital signs monitoring or exchanges (e.g., Tele-ICU, Tele-stroke)

## Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “plan” through which you may have other coverage for health care expenses we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Provider sponsored integrated health delivery network

- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group
- Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA
- Any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky and does not include policies listed below.

The definition of a plan does not include:

- No fault contracts and traditional automobile "fault" contracts
- Student accident only insurance
- Any health benefit plan as specified by Kentucky state law

### How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

### 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	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> <li>• Plan of parent responsible for health coverage in court order</li> <li>• Birthday rule applies if both parents are responsible or have joint custody in court order</li> <li>• Custodial parent's plan if there is no court order</li> </ul>	<ul style="list-style-type: none"> <li>• Plan of other parent</li> <li>• Birthday rule applies (later in the year)</li> <li>• Non-custodial parent's plan</li> </ul>

<b>COB rule</b>	<b>Primary Plan</b>	<b>Secondary plan</b>
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

### **How COB works with Medicare**

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it.

### **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.

### **Other health coverage updates – contact information**

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

### **Our rights**

We have the right to:

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

### **Converting from a group to an individual health plan**

When your group health plan ends, you may be eligible to change to an individual health plan.

### **When are you eligible for a conversion plan?**

You are eligible if:

- You had group health coverage under this plan continuously for the last 3 consecutive months before your coverage ended, and

- Your COBRA coverage has ended and you aren't eligible for additional extensions

You are not eligible if:

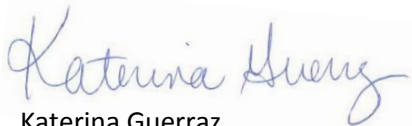
- You did not pay your premium contributions under this plan.
- This plan ends because the contract between the group and us ends and is replaced by another group plan within 31 days.
- You are eligible for health coverage under another group plan.
- You are eligible for Medicare coverage, whether or not you have actually enrolled in Medicare.
- You are already covered under an individual health plan.

### **How you apply for a conversion plan**

To apply:

- The policyholder will send you a notice that says you are eligible for a conversion plan. They must send you this notice 31 days after your group plan with us ends.
- We must receive your application and your first premium payment within 45 days after your group plan ends.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Kentucky Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Acupuncture

**Covered services** include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

### Ambulance service

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person by ground, air or water.

### Emergency

**Covered services** include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first facility can't provide the **emergency services** you need
- For your newly born child and disabled mother to a **hospital** or neonatal unit

### Non-emergency

**Covered services** also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance
- For your newly born child and disabled mother to a **hospital** or neonatal unit

For the purpose of this benefit:

- A "newly born child" means a child from birth to one month old, or until the infant is well enough to go home. This may take longer than one month.

- A “disabled mother” means a woman who has recently given birth and whose **physician** has advised her that normal travel may be harmful to her health.

The following are not **covered services**:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

## **Attention deficit/hyperactivity disorder (ADHD)**

**Covered services** include certain outpatient services and supplies for the diagnosis and treatment of ADHD by a **physician, hospital** or other licensed health care **provider**.

**Covered services** is a syndrome or disordered learning and disruptive behavior. It is not caused by any serious underlying physical or mental disorder. It is characterized primarily by:

- Inattentiveness
- Hyperactivity and impulsive behavior or by the significant expression of both

ADHD outpatient service and supplies include:

- Medical evaluation, including diagnostic testing and lab services
- **Prescription** drugs
- Psychosocial treatment
- Other services and supplies received from a **physician, hospital** or other licensed health care **provider**

## **Autism spectrum disorder**

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

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech and language pathology therapy associated with the diagnosis of autism spectrum disorder

## **Cleft lip and cleft palate**

**Covered services** include the treatment and correction of cleft lip and-palate. This coverage shall include benefits for secondary conditions and treatment attributable to that primary medical condition. **Covered services** include services and supplies:

- Oral and facial **surgery**, including care by a **physician** before and after **surgery**
- Prosthetic treatment such as:
  - Obturators
  - Speech appliances
  - Feeding appliance
- Orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health
- Adequate dental structures for orthodontic treatment
- Prosthetic management or therapy
- Speech-language evaluation and therapy
- Audiological assessments and management
- Otolaryngology treatment
- Psychological assessment and counseling
- Genetic assessment and counseling for you, your dependent child and the child’s parents

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

## Clinical trials

### Routine patient costs

**Covered services** include routine patient costs 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.

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, prevention, detection, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer or other life-threatening disease or condition. All of the following conditions must be met:

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

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

An approved clinical trial is 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

## Dental care anesthesia

**Covered services** include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist’s office due to either age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

## Diabetic services, supplies, equipment, and self-care training and education 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 training and education programs with a health care **provider** certified in diabetes self care training, including medical nutrition therapy

## Diagnostic lab work

**Covered services** include:

- Lab
- Pathology
- Genetic or molecular testing for cancer including but not limited to:
  - Tumor mutation testing
  - Next generation sequencing
  - Hereditary germline mutation
  - Whole exome and genome sequencing
  - Biomarker testing
- Advanced molecular techniques for a critically ill infant including but not limited to:
  - Traditional whole genome sequencing
  - Rapid whole genome sequencing
  - Other genetic and genomic screenings that include:
    - Individual sequencing
    - Trio sequencing for a parent or parents of the infant
    - Ultra-rapid sequencing for an infant one year of age or younger that is receiving inpatient services in an intensive care unit or a pediatric care unit and has a complex illness of unknown etiology
- Other tests

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

## Hearing aids for minors

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

Hearing aid means:

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

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

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

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

The following are not **covered services**:

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

### **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 medical services that are proven to result in **infertility** such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - **Surgery** or other medical treatment for cancer that is established by the American Society for Reproductive Medicine or the American Society of Clinical Oncology
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna’s **infertility** clinical policy

**Covered services** include:

- Evaluation
- Labs
- Medication and treatment associated with oocyte and sperm cryopreservation procedures, including obtaining, freezing and storing gametes for three (3) years

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

### **Jaw joint disorder treatment**

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

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

### **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 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

### **Mail order pharmacy**

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

**Prescriptions** can be filled at a network **mail order pharmacy**.

### **Maternity and related newborn care**

**Covered services** include pregnancy (prenatal) care, care after delivery and obstetrical services, including maternity support provided by a doula before, during and delivery. 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 inpatient and outpatient use for up to 2 months of **medically necessary** donated pasteurized human breast milk obtained from a milk bank when prescribed by a licensed **health professional** for an infant who is medically or physically unable to receive maternal human breast milk or participate in chest feeding or whose mother is medically or physically unable to produce maternal human breast milk in sufficient quantities.

If the mother is discharged earlier, the plan will pay for 1 home visit after delivery by a health care **provider**.

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

The following are not **covered services**:

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

### **Obesity surgery and services**

Obesity **surgery** is a type of procedure performed on people age 18 and over who are severely obese for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

**Covered services** include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription** drugs included under the *Prescription drugs – outpatient* section
- An obesity **surgical procedure**
- A multi-stage procedure when planned and approved by us

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

The following are not **covered services**:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

### **Anti-cancer drugs taken by mouth**

**Covered services** include any drug prescribed for cancer treatment, including chemotherapy drugs. 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. Oral anti-cancer drug benefits will have parity with intravenous (IV) anti-cancer drugs.

### **Osteoporosis**

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

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

### **Prosthetic device and services**

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 prosthetic service means the science and practice of:

- Evaluating
- Measuring
- Designing
- Fabricating
- Assembling
- Fitting
- Aligning
- Adjusting
- Services of a prosthesis through the replacement parts of a human body loss due to amputation or congenital deformities to restore function, cosmesis or both. It also includes any **medically necessary** clinical care.

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

Coverage includes:

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

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

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

The following are not **covered services**:

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

## Reconstructive breast surgery and supplies

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

- All stages of reconstruction of the breast on which a unilateral mastectomy has been performed and on the other breast to produce a symmetrical appearance including:
  - Contralateral prophylactic mastectomies
  - Liposuction performed for transfer to a reconstructed breast or repair donor site deformity
  - Tattooing the areola of the breast
  - Surgical adjustments of the of the non-mastectomized breast
  - Unforeseen medical complications which may require additional reconstruction in the future
  - Prostheses and physical complications
  - Lymphedema
- All stages of reconstruction of both breasts if a bilateral mastectomy has been performed including:
  - Liposuction performed for transfer to a reconstructed breast or repair donor site deformity
  - Tattooing the areola of the breast
  - Unforeseen medical complications which may require additional reconstruction in the future
  - Prostheses and physical complications
  - Lymphedema
- Breast reconstruction procedures to be performed shall be made solely by the patient in consultation with attending **physicians** regardless of whether a partial mastectomy or a full unilateral or bilateral mastectomy is chosen by the patient and **physician**
- Preventive cancer screenings, on no less than an annual basis, for an insured or enrollee who:
  - Was previously diagnosed with breast cancer
  - Completed treatment for breast cancer
  - Underwent a bilateral mastectomy
  - Was subsequently determined to be clear of cancer

## Well woman preventive visits

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

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

## Routine cancer screenings

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Capsule colonoscopy
- CT colonoscopy
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal immunochemical test (FIT) for blood
- Fecal immunochemical test (FIT) – fecal DNA test
- Fecal Occult Blood Tests (FOBT)
- Flexible Sigmoidoscopies
- Lung cancer screenings
- Mammograms, including diagnostic imaging and ultrasound screening designed to evaluate an abnormality
- Prostate specific antigen (PSA) tests\*
- Sigmoidoscopies

**Important note:**

\*Prostate cancer screening includes a second visit when **medically necessary** and follow-up treatment within sixty days after either visit, if related to a condition diagnosed or treated during the visits.

## Telehealth

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

**Covered services** for **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 **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, except if after access and review of the patient’s medical records, the **physician, specialist, behavioral health provider** or other **telehealth provider** decision meets the same standard of care if the health care services were provided in person
- **Telehealth** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

### Treatment of metastatic or unresectable tumors or other advanced cancers

**Covered services** include FDA-approved drugs for the treatment of metastatic or unresectable tumors or other advanced cancers with a **medically necessary** drug prescribed by a **physician** on the basis that the drug is not indicated for the specified tumor type or location in the body of the patient’s cancer, even if the drug isn’t approved by the FDA for the treatment of the specific mutation in a different type of cancer. After an initial treatment period of a minimum of 3 months, treatment can continue if your treating **physician** certifies that the drug is **medically necessary** based on your documented improvement through clinical trials as being more effective for your condition, we may deny coverage for these drugs.

**Important note**

You or your **employer** are responsible for the payment of any tax that applies to **prescription** drugs that are **covered services** under your plan. Please check with your **employer**.

## Translation charges

**Covered services** include services for translation charges for a qualified interpreter/translator related to covered medical treatment or diagnostic consultations performed by a **physician**. This is available to you if the services are required because you are deaf, hard of hearing, have a hearing loss or you cannot understand or communicate in spoken language. The interpreter/translator cannot be a family member.

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

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

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

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

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud, lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

#### Important note:

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

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

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

This provision does not apply:

- If you:
  - Move out of the geographic service area of the plan
  - Choose to change **provider**
- If the **provider**:
  - Moves out of the geographic service area of the plan
  - Does not consent to continue to provide services

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

### Step therapy

Step therapy is a type of **precertification** under which certain **prescription drugs** are excluded as coverage unless a first-line therapy drug is first used by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request on our website at <https://www.aetna.com/individuals-families/find-a-medication.html>. We will also tell you which drugs are excluded from the step therapy process.

We will make a therapy determination within 72 hours of receiving all the claim information from the prescribing **provider**. Urgent situations will be handled within 24 hours of receiving all the clinical information from the prescribing **provider**. Step therapy exception requests from the prescribing **provider** must clinically show that one of the following is true:

- The preferred treatment has been ineffective in the past treatment the patient’s disease or medical condition while tried during the patient’s current or previous health insurance plan.
- The preferred treatment can be expected to be ineffective based on known physical or mental characteristics of the patient vs. characteristics of the drug regimen.
- The preferred treatment is contraindicated or will likely cause an adverse reaction to the patient.
- The patient is currently receiving a positive outcome on the requested **prescription** drug for the medical condition in question under their current health plan or immediately preceding health plan, under which the drug was a covered benefit.
- The preferred treatment is not in the best interest of the patient as evidenced by valid documentation submitted by the prescriber.

If the step therapy exception request submitted by the **provider** meets any of the clinical criteria above, and the agreed to turn around time is missed, we agree to deem the request as approved.

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

### **Requesting a medical exception**

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

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

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

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your prescriber of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above process, you may have the right to a third party review by an independent review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send represents you or your prescriber of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker medical exceptions in urgent situations, we will tell you, or someone who represents you or your prescriber of the coverage determination no later than 24 hours after we receive you request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation. See the *External review* section for the IRO process.

### **Coordination of benefits**

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

The order of benefit determination rules govern the order in which each plan will pay a claim for

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

## Key Terms

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

Allowable expense means:

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

Claim determination period or plan year a period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefit payable in the absence of COB to determine whether over-insurance exists and how much each plan will pay or provide:

- The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group or individual contact. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.
- As each claim is submitted, each plan determines its responsibility and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination.

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

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

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

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

A plan does not include:

- Hospital indemnity coverage
- Accident only
- Specified disease or specified accident coverage

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

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

### How COB works

- When this is the primary plan, we pay your medical claims first as if the other plan does not exist
- When this is your secondary plan:
  - We will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
  - Total payment from this plan and your other coverage will never add up to more than 100% of the allowable expenses

### Determining who pays

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

A plan that does not contain a COB provision is always the primary plan pursuant to Regulation 32 COB Model.

COB rule	Primary plan	Secondary plan
Non-dependent or dependent	Plan covering you as an <b>employee</b> , retired <b>employee</b> or subscriber (not as a dependent)*	Plan covering you as a dependent
*Exception when you are a Medicare beneficiary	<p>If you or your spouse is a Medicare beneficiary:</p> <ul style="list-style-type: none"> <li>• And as a result of federal law, Medicare is secondary to the plan covering you or your spouse as a dependent</li> <li>• And primary to the plan covering the person as other than a dependent (e.g. a retired <b>employee</b>)</li> <li>• Then the order of benefits between the two plans is reversed so that the plan and covering the person as an <b>employee</b> or retired <b>employee</b> is the secondary plan and the other plan is the primary</li> </ul> <p>If you have any questions about this you can contact us:</p> <ul style="list-style-type: none"> <li>• See the section <i>How COB works with Medicare</i> below.</li> <li>• Online: Log on to your secure member website at <a href="http://www.aetna.com">www.aetna.com</a>.</li> <li>• Select Find a Form, then select Your Other Health Plans</li> </ul> <p>By phone: Call the toll free number on your ID card</p>	
Child – parents married or living together, whether or not ever married	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)*	Plan of parent whose birthday is later in the year

*Birthday rule - Parents with the same birth date	The plan that has covered a parent longer will be primary	
Child – parents separated, divorced, or not living together, whether or not ever married	<ul style="list-style-type: none"> <li>• Plan of parent responsible for health coverage in court order*</li> <li>• Birthday rule applies if both parents are responsible or have joint custody in court order</li> <li>• Custodial parent’s plan if there is no court order</li> <li>• Plan of the parent’s spouse, if parent has no coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Plan of other parent</li> <li>• Birthday rule applies (later in the year)</li> <li>• Non-custodial parent’s plan</li> <li>• Plan of the other parent’s spouse, if parent has no coverage</li> </ul>
*Court order	<ul style="list-style-type: none"> <li>• Applies to plan years beginning after the plan has been provided notice of the court order</li> <li>• When court order states both parents are responsible for health coverage or they have joint custody and the court didn’t state that one parent is responsible for child health coverage, benefit order defaults to Birthday Rule.</li> </ul>	
*No court order	<ul style="list-style-type: none"> <li>• The plan of the custodial parent pays first</li> <li>• The plan of the spouse of the custodial parent (if any) pays second</li> <li>• The plan of the noncustodial parent pay next</li> <li>• The plan of the spouse of the noncustodial parent (if any) pays last</li> </ul>	
Child – covered under more than one plan by individuals who are not parents (i.e., stepparent or grandparent)	Same rule as parent	Same rule as parent
Child – covered under either or both parent’s plans and is also covered as a dependent on a parent’s spouses plan	<ul style="list-style-type: none"> <li>• See Longer or shorter length of coverage (below)</li> <li>• In the event coverage began at same time, see birthday rule (above)</li> </ul>	
Active or inactive <b>employee</b>	Plan covering you as an active <b>employee</b> (or dependent of an active <b>employee</b> )	Plan covering you as a laid off or retired <b>employee</b> (or dependent of a former <b>employee</b> )
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state or federal continuation*	Plan covering you as an <b>employee</b> or retiree (or dependent of an <b>employee</b> or retiree)	COBRA, state or federal continuation coverage
*If a plan does not have this rule, and as a result the plans do not agree on the order of benefits, this rule is not applied		
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time

If other rules noted above do not apply	<ul style="list-style-type: none"> <li>• Plans share expenses equally</li> <li>• This plan will not pay more than it would as the primary plan</li> <li>• If a plan does not have this rule, and as a result the plans do not agree on the order of benefits, this rule is not applied</li> </ul>
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**How are benefits paid?**

Primary plan	The primary plan pays your claims as if there is no other health plan involved
Secondary plan	<p>Effect of the benefits when the plan is secondary:</p> <ul style="list-style-type: none"> <li>• It may reduce its benefits so that the plans during a year are not more than the total allowable expenses</li> <li>• In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan</li> <li>• May then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim</li> <li>• Shall credit to its plans <b>deductible, coinsurance, copayments</b> and any amount it would have credited to its <b>deductible</b> in the absence of other health care coverage</li> <li>• It may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100% of total allowable expenses</li> </ul>
Benefit reserve*	<p>The benefit reserve when this plan is the secondary plan:</p> <ul style="list-style-type: none"> <li>• Is the difference between the benefit payments that this plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period</li> <li>• As each claim is submitted will determine: <ul style="list-style-type: none"> <li>- Its responsibility to pay or provide benefits under its contract</li> <li>- Whether a benefit reserve has been recorded for the covered person</li> <li>- Whether there are any unpaid allowable expenses during that claims determination period</li> </ul> </li> <li>• Will use the covered person’s benefit reserve to pay up to 100% of the total allowable expenses incurred during the claim determination period</li> <li>• At the end of the claim determination period, the benefit reserve returns to zero</li> <li>• A new benefit reserve must be created for each new claim determination period</li> </ul>

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

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

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

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

- Online: Log on to your secure member website at [www.aetna.com](http://www.aetna.com)
- By phone: Call toll-free number on your ID card

### How COB works with Medicare

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

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

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

### Who pays first?

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

### If you have Medicare because of:

End stage renal disease (ESRD)	Your plan will pay first for the first 30 months	Medicare
	Medicare will pay first after the 30 months	Your plan
Disability other than ESRD and the policyholder has more than 100 <b>employees</b>	Your plan	Medicare

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

This plan is secondary to Medicare in all other circumstances.

### How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved
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Medicare is primary	We calculate our benefits as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expenses
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Charges that satisfy Part B **deductible** will be applied in the order received. We will apply the largest charges first when two or more charges are received at the same time.

**Effect of prior plan coverage**

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

**Other health coverage updates – contact information**

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

**Right to receive and release needed information**

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

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

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

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

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

**Right to pay another carrier**

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

**Right of recovery**

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

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

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

**Summary of Coordination of benefits procedures**

## IMPORTANT NOTICE

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

### Double coverage

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

### Primary or secondary?

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

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

### When this plan is primary

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

- Your own expenses
- Your spouse’s expenses
- Your child’s expenses

### Other situations

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

### How we pay claims when we are primary

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

### How we pay claims when we are secondary

We will be secondary whenever the rules do not require us to be primary.

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

- If there is a difference between the amount the plans allow, we will base our payments on the higher amount. However, if the primary plan has a contract with **provider**, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their **providers**.
- We will determine our payment by subtracting the amount the primary plan paid from the

amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefits because you did not obtain pre-authorization, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.
- Benefit reserve
- When are secondary we often will pay less than we would have paid if we had been primary. Each time we “save” by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the saving. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year each balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?  
Contact your state insurance department

## **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 as soon as possible or within 2 days. If additional information is needed, we will tell you our decision as soon as possible, but no later than 48 hours from receipt of the additional information.

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 business days. If additional information is needed, we will tell you our decision as soon as possible, but no later than 5 business days from receipt of the additional information.

#### **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 as soon as possible but not less than within 24 hours of obtaining all necessary information from the **provider** or facility. You may receive the decision for a non-urgent request within 15 days.

### **Concurrent care claim reduction or termination**

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

During this continuation period, you are still responsible for your share of the costs, such as **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.

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

- We pay many claims at the full rate negotiated charge with a **network provider** and the **allowable amount** with an **out-of-network provider**, except for your share of the costs. Sometimes we pay only some of the claim and sometimes we don't pay at all.
- A review that denies, reduces, terminates or fails to provide or make a payment in full or in part, for the benefit based on a determination by us or its review organization of the covered person's eligibility to participate in our health benefit plan.
- Any pre-service review or post-service review that denies, reduces, or terminates, or fails to provide or make payment, in whole or in part, for a benefit under the health plan.
- A rescission of coverage determination. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.
- External reviews shall apply only to adverse benefit determinations and final adverse benefit determination that involve:
  - Medical judgement
  - Appropriateness
  - Health care setting
  - Level of care
  - Effectiveness of a covered benefit
  - A service, supply, or treatment is experimental or investigational
  - Rescission

### **Authorized representative**

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

- Your immediate family member or your treating **health professional** when you are unable to provide consent.
- In the case of an urgent care request, a **health professional** with knowledge of your medical condition.

## Grievance

A grievance is a type of written or oral complaint, it may involve an urgent care request on your behalf. about any of the following:

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

You or your provider can call the toll-free number on the back of your ID card or write Member Services at P.O. Box 14462 Lexington, KY 40512 to let us know about your grievance.

## Filing a claim

These procedures apply to claims involving out-of-network **providers** that are not surprise bill claims. All surprise bill clean claims will be paid within 30 days. See the Surprise bill provision in *What the plan pays and what you pay* section for more information.

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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay a paper claim within 45 days and an electronic claim within 25 days from when we received all of the information necessary. When a paper claim is received more than 45 days from the date of service, we will pay that claim within 60 days. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and, appeal procedures* section for that information.

## Complaints, claim decisions and appeal procedures

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### 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**

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

## **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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

## **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. We will give you an answer within 72 hours for a level 1 and 2 urgent appeal. We will give you an answer within 15 calendar days for a level 1 pre-service appeals and within 5 days for a level 2 pre-service appeal. A concurrent claim appeal will be addressed 2 days after the adverse determination.

### **Any other claim appeal**

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 contacting us. You need to include:

- Your name
- The plan sponsor’s name
- A copy of the adverse benefit 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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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

Louisiana Department of Insurance  
Office of Consumer Services  
Post Office Box 94214

You may also call the toll-free number 1-800-259-5300 or visit the LDI website at [www.lidi.la.gov](http://www.lidi.la.gov).

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

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 Louisiana. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

### External review

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

The types of External reviews are:

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

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

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

- We rescind your coverage

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

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

You may submit an oral or written request for an external review form:

- To Aetna
- At the time or within 4 months of the date you receive the decision from us adverse determination, when you are requesting an expedited external review
- With a copy of the notice from us, along with any other important information that supports your request

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

We will:

- Notify the Louisiana Department of Insurance of the request for an external review
- Submit a request for assignment to an IRO that will conduct the review of your claim

The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

### **How long will it take to get an IRO decision?**

The IRO will give us, you and the Louisiana Department of Insurance a 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 an expedited external review decision. You or your authorized representative must call us or send us a request for external review form.

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

#### **For initial adverse benefit determinations**

- Your **provider** tells us a delay in receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away and can cause an imminent threat to your health (in the case of **experimental or investigational** treatment)

## Timeframes for external review decisions

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

Type of external review	When we complete a preliminary review of the request and notify you	When the review request is assigned to the IRO	When the IRO completes their review and notifies you
Standard external review	Within 5 business days after the date of receipt of the notice	Within 1 business day after receiving request from Aetna	<p>Within 45 days after the date of receipt of the request to complete the review, or</p> <p>IRO has 1 business day after making their decision to send a written notice</p>
Expedited external review (oral or written)	Immediately after receiving request	Immediately after receiving request from Aetna	As soon as possible but no longer than 72 hours after getting assigned
Standard external review of experimental or investigational treatment adverse determination	Within 5 business days after receiving request to determine eligibility	Within 1 business day after the date of receiving request from Aetna	Within 20 days after the date it receives the opinion of each clinical peer to make a decision (clinical peers have 20 days to provide a written opinion to IRO)
Expedited review of experimental or investigational treatment adverse determination	Immediately after receiving request	Immediately after receiving request from Aetna	<p>As soon as possible but no longer than 8 days after receipt of assignment</p> <p>The decision may take up to 8 days because the:</p> <ul style="list-style-type: none"> <li>• IRO has 1 day after receiving the request to assign the review to clinical review</li> <li>• Clinical peers shall provide an oral or written opinion to</li> </ul>

			<p>the IRO as soon as possible but no longer than 5 days of being assigned</p> <ul style="list-style-type: none"> <li>• IRO has 48 hours after the date it receives the opinion of each clinical peer to make a decision</li> </ul>
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\*You will be sent a written notice, if your request is considered:

- Incomplete because of missing information. This notice will include what information or materials are needed to complete your request.
- Not eligible for the external review. This notice will include the reasons why it is not eligible.

Also, you have the right to have the adverse determination reviewed by the Louisiana Department of Insurance.

### Utilization review

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

### Recordkeeping

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

### Fees and expenses

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

### 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
  - You and your domestic partner will need to complete and sign a Declaration of Domestic Partnership. Contact the policyholder for the form. [To eligible for coverage, a domestic partner is a person who certifies the following as of the date of enrollment:
    - He or she is your sole domestic partner and intends to remain so indefinitely
    - He or she is not married or legally separated from anyone else
    - He or she is not registered as a member of another domestic partnership within the past 6 months
    - He or she is of the age of consent in your state of residence
    - He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
    - He or she has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabitate and reside with you indefinitely
    - He or she is engaged with you in a committed relationship of mutual caring and support, and

jointly responsible for your common welfare and living expenses

- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - o Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
  - o Common ownership of a motor vehicle
  - o Driver's license with a common address
  - o Proof of joint bank accounts or credit accounts
  - o Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
  - o Assignment of a durable property power of attorney or health care power of attorney.
- Dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - o under age 26, and they include:
  - Dependent children include:
    - o Natural children
    - o Stepchildren
    - o Adopted children including those placed with you for adoption
    - o Foster children
    - o Children you are responsible for under a qualified medical support order or court order
    - o Grandchildren in your legal custody
    - o A grandchild whose parent is already covered as a dependent on this plan
    - o Any child placed in your home due to the execution of an act of voluntary surrender

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

To enroll an out of area dependent on this plan (if applicable to your plan):

- You must be enrolled as an **employee** in a different Aetna plan option offered by the **policyholder**
- Your eligible dependent must live outside your plan's service area

### **When you are injured**

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

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

- Agreeing to repay us from money you receive because of your injury.
- 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.

After you have been paid in full defined by any law that applies, we ask that you repay us for the care you received because of your injury or illness. We will share in the cost for your lawyer, claim, or lawsuit as long as we are repaid for the amount we paid for your care. When we don't receive your help, we don't have to reduce

the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred for your recovery.

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

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style and is positioned above a light gray rectangular box.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Louisiana ET Rider  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Massachusetts. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

TTY: 711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Arabic	لحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាភាសាឥតគិតថ្លៃ បំណែកអ្នក ត្រូវប្រើលេខស្រីកាត់សុខាភិបាលលេខ ២១ លើកាត់សុខាភិបាលរបស់លោក/លោកស្រី។
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Hindi	धन्य क सभ से बिना कौन से भी खर्च के, अपने आईडी कार्ड पर नमूद नंबर पर कॉल करें।
Gujarati	તમારું કોઈ પણ જાતના ખર્ચ વિના [1]થી સે [2]વિના [3] વગર, તમારા આઈડી કાર્ડ પર [4] નંબર પર [5] કરો [6]।

**Physician Profiling**

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

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at <https://www.aetna.com/>

## **Important Note: The benefit differential between Network and Out-of-Network coverage will not exceed 20%**

### **Behavioral health**

#### **Mental health treatment**

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
  - Office visits to a **physician or behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation), including services provided in relation to the psychiatric collaborative care model of care
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist (including telemedicine consultation)
- Mobile crisis intervention, which is a short-term, mobile, on-site, face-to-face therapeutic response service available 24-hours a day, 7 days a week to an adult experiencing a behavioral health crisis. Requirements include:
  - This must provide the following services:
    - Identify, assess, treat and stabilize a situation
    - Reduce the immediate risk of danger to the adult or others
    - Make referrals and linkages to behavioral health services and supports and the appropriate level of care
  - Must be consistent with the adult's risk management or safety plan, if applicable.
  - Includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.
- Community-based acute treatment for adults (CBAT) are mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the adult, while

providing intensive therapeutic services. These can be used as an alternative to or transition from inpatient services and include, but are not limited to:

- Daily medication monitoring
- Psychiatric assessment
- Nursing availability
- Specialing (as needed)
- Individual, group and family therapy
- Case management
- Family assessment and consultation
- Discharge planning
- Psychological testing, as needed

**Eligible health services** include the diagnosis and treatment for rape related mental or emotional disorders. It also includes psychopharmacological services and neuropsychological assessment services.

**Eligible health services** also include the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders as described in the most recent edition of the DSM for children and adolescents under the age of 19. These disorders can include but is not limited to the following:

- Inability to attend school
- Need to hospitalize the child or adolescent
- A pattern of conduct or behavior which poses a serious danger to self or others

#### **Child-adolescent mental disorders treatment**

**Eligible health services** include intermediate care and outpatient services for the treatment of child-adolescent **mental disorders** as follows:

- In-home behavioral services which must be provided where the child resides and include:
  - Behavioral management monitoring which consists of
    - Monitoring a child's behavior
    - Implementing and reinforcing a behavior plan by the child's parent or caregiver
  - Behavior management therapy which addresses behaviors that interfere with a child's successful functioning, and includes:
    - A functional behavioral assessment and observation of the youth in the home and/or community setting
    - development of a behavior plan
    - supervision and coordination of interventions to address specific behavioral objectives or performance, including development of a crisis-response strategy
    - short-term counseling and assistance
- In-home therapy which must be provided where the child resides and include:
  - Therapeutic clinical intervention such as:
    - A structured and consistent therapeutic relationship between a licensed clinician, a child, and the child's family to treat the child's mental health needs. This includes improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family.
    - Development of a treatment plan
    - Use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance:
      - Problem solving
      - Limit setting
      - Communication

- Emotional support
  - Other family or individual functions
- Ongoing therapeutic training and support services that support implementation of a treatment plan in accordance with therapeutic clinical intervention, including but not limited to:
  - Teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations
  - Assisting the family in supporting the child and addressing the emotional and mental health needs of the child
- Mobile crisis intervention, which is a short-term, mobile, on-site, face-to-face therapeutic response service available 24-hours a day, 7 days a week to a child experiencing a behavioral health crisis. Requirements include:
  - This must provide the following services:
    - Identify, assess, treat and stabilize a situation
    - Reduce the immediate risk of danger to the child or others
    - Make referrals and linkages to behavioral health services and supports and the appropriate level of care
  - Must be consistent with the child’s risk management or safety plan, if applicable.
  - Includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.
- Intensive care coordination is a collaborative service providing targeted case management services to children and adolescents with a serious emotional disturbance, including co-occurring conditions. It must be based on a system of care philosophy, with an individualized care plan tailored to meet the needs of the individual. It is designed to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual’s family. Services may be delivered in office, home or other settings, as clinically appropriate and include
  - An assessment
  - Development of an individualized care plan
  - Referrals to appropriate levels of care
  - Monitoring of goals
  - Coordinating with other services and social supports and with state agencies
- Community-based acute treatment for children and adolescents (CBAT) are mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services. These can be used as an alternative to or transition from inpatient services and include, but are not limited to:
  - Daily medication monitoring
  - Psychiatric assessment
  - Nursing availability
  - Specialing (as needed)
  - Individual, group and family therapy
  - Case management
  - Family assessment and consultation
  - Discharge planning
  - Psychological testing, as needed
- Intensive community-based treatment for children and adolescents (ICBAT) provides the same services as CBAT to children and adolescents, but of higher intensity. This includes more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery and;
  - Provides programs that have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. These programs treat children and adolescents with

- clinical presentations similar to those referred to inpatient mental health services but who are cared for safely in an unlocked setting.
- Requires that children and adolescents be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization.
  - However, CBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.
  - Family support and training. These services, provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child’s emotional or behavioral needs.
    - The service must be provided where the child resides. This includes:
      - The child’s home
      - A foster home
      - A therapeutic foster home
      - Another community setting
    - Family support and training addresses one or more goals on the youth’s behavioral treatment plan and may include:
      - Educating parents/caregivers about the youth’s behavioral health needs and resiliency factors
      - Teaching parents/caregivers how to navigate services on behalf of the child
      - Teaching parents/caregivers how to identify formal and informal services and supports in their communities, including parent support and self-help groups
  - Therapeutic mentoring services. These services, provided to a child, are designed to support or improve deficits in the child’s age-appropriate social functioning. Requirements include:
    - Services include supporting, coaching and training the child in:
      - Age-appropriate behaviors
      - Interpersonal communication
      - Problem solving
      - Conflict resolution
      - Relating appropriately to other children, adolescents and adults
    - Services must be provided, when indicated, where the child resides, including:
      - The child’s home
      - A foster home
      - A therapeutic foster home
      - Another community setting
    - Therapeutic mentoring is a skill building service addressing one or more goals of the child’s behavioral health treatment plan.
    - Therapeutic mentoring may also be delivered in the community, to allow the child to practice desired skills in appropriate settings.

The following are not **eligible health services**

- Programs in which the patient has a pre-defined duration of care that doesn’t allow us to conduct concurrent determinations of continued medical necessity for an individual
- Programs that only provide meetings and activities that are not based on individualized treatment planning
- Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific mental health disorders
- Tuition-based programs that offer educational, vocational, recreational, or personal development activities such as a therapeutic school, camp or wilderness program. Except, that eligible health services include services provided while the individual is in the program, subject to all other terms of this certificate
- Programs that provide primarily custodial care services

## 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**.
- 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**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (including telemedicine consultation)

### Behavioral health important note:

A peer support specialist serves as a role model, mentor, coach, and advocate. A peer support specialist must be supervised by a **behavioral health provider**.

## 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)

## 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
  - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

## 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.

**Covered services** include:

- Speech and language therapy
- Occupational therapy
- Physical therapy
- Assistive technology

## 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 or a licensed hearing instrument specialist
  - 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

## Infertility services

**Covered services** include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs.

## Advanced reproductive technology (ART)

Advanced reproductive technology, also called “assisted reproductive technology”, is a more advanced type of infertility treatment.

**Covered services** include the following services provided by a network ART **specialist**

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- In vitro fertilization (IVF).
- Embryo transfer (ET).
- 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.
- 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.)
- **Prescription** drugs injected by your **provider** to stimulate the ovaries.

The National Infertility Unit (NIU) can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility Institutes of Excellence™(IOE) facilities. You can call the NIU at 1-800-575-5999.

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

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

**Premature ovarian insufficiency**

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

**Infertility services exclusions:**

The following are not **covered services**:

- 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.
- Infertility medication not injected by your **provider**, including but not limited to menotropins, hCG, and GnRH agonists. See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs for your plan.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when 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 or other abnormal testing results as outlined in Aetna’s infertility clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.

**Infertility services**

Description	In-network	Out-of-network
Treatment of infertility	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## Advanced reproductive technology (ART)

Description	In-network	Out-of-network
Outpatient services performed at ART <b>specialist</b> office	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at <b>hospital</b> outpatient department	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at a facility other than a <b>hospital</b> outpatient department	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Fertility preservation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## 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

## Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

**Covered services** include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting us.

**Covered services** also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with the streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient **prescription** drug benefit. You can access the list of **specialty prescription drugs** by contacting us.

## Routine physical exams

A routine 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:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women
- Annual mental health wellness examination. This means a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment.

**Covered services** include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

## Telemedicine

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

**Covered services** for **telemedicine** 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 provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

You always have the option to obtain **covered services** from a **provider** on an in-person basis. See the *Physician services* section and the schedule of benefits for more information.

You won't be subject to a **medical necessity** determination to ascertain whether you are eligible to obtain **covered services** on an in-person basis rather than by **telemedicine**.

The following are not **covered services**:

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

## Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

- Allowable expense means a health care expense that any of your health plans cover.
- MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy.
- PIP means the personal injury protection coverage included in a motor vehicle liability policy.

In this section when we talk about “plan” through which you may have other coverage for health care expenses we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

## How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

## 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	Secondary plan
A motor vehicle policy and are injured as a result of an accident with a motor vehicle	PIP is the primary plan for the first \$2,000 of expenses. After that, plans will coordinate benefits in accordance with these COB provisions.	The plan which is not a motor vehicle policy
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year

Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> <li>• Plan of parent responsible for health coverage in court order</li> <li>• Birthday rule applies if both parents are responsible or have joint custody in court order</li> <li>• Custodial parent’s plan if there is no court order</li> </ul>	<ul style="list-style-type: none"> <li>• Plan of other parent</li> <li>• Birthday rule applies (later in the year)</li> <li>• Non-custodial parent’s plan</li> </ul>
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

### How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

You are eligible for Medicare if you are covered under it.

### Effect of prior plan coverage

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

### Other health coverage updates – contact information

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

### Our rights

We have the right to:

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

### How do you extend coverage if you leave your job

If your employment ends because you leave your job, you may continue benefits for you and your dependents for 31 days. You must ask that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Benefits will end before the end of the 31 days on the first of:

- The date you are eligible for benefits under another group plan
- The date you fail to make any premium contribution needed

#### **How do you extend coverage if your plant closes**

If your employment ends due to a plant closing or partial closing, you may continue benefits (except dental coverage) for you and your dependents for 90 days. You must ask that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Benefits will end before the end of the 90 days on the first of:

- The date you are eligible for benefits under another group plan
- The date you fail to make any contribution needed

#### **How do you extend coverage for a former spouse**

If you get divorced or separated from your spouse, your former spouse may continue to be covered unless a court judgment or divorce decree specifies otherwise, the same dependent premium and contribution rates will apply.

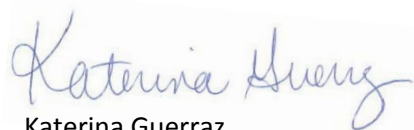
Benefits will end on the earliest of:

- The date specified in a judgment or decree
- The date your former spouse remarries
- The date you remarry
- The date you are no longer covered by the policy

In the event you remarry, your former spouse has the right, if so provided in the judgment, to continue to receive coverage under this agreement. If the judgment provides for this continuation of benefits, your former spouse may continue coverage under the group plan until the date specified in the judgment, the date your former spouse remarries or the date that you are no longer covered by the policy

Notice of cancellation of coverage of your divorced or separated spouse will be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Massachusetts Medical ET

Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Maryland. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Cleft lip and palate

**Covered services** include inpatient and outpatient expenses for orthodontics, oral surgery, otologic, audiological, and speech/language treatment for cleft lip and/or palate.

### Osteoporosis

**Covered services** include the prevention, diagnosis, treatment and management of osteoporosis by a **physician**. The services include Food and Drug Administration approved technologies, including bone mass measurement for qualified individuals.

Qualified individual means:

- An estrogen deficient individual at clinical risk for osteoporosis;
- An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
- An individual receiving long-term glucocorticoid (steroid) therapy;
- An individual with primary hyperparathyroidism; or
- An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

### Continuity of care when you are a new enrollee to the plan

If you are transitioning coverage from:

- One health insurer to another health insurer
- The Maryland Medical Assistance Program to a carrier and only to behavioral health and dental benefits, to the extent they are authorized by a third-party administrator

You shall continue to receive health care services by an out-of-network **provider** for the following:

- Acute conditions

- Serious chronic conditions
- Pregnancy
- Mental health conditions and substance use disorders
- Other conditions we and the **provider** or facility agree on

At your or your parent, guardian designee or health care provider request, we shall accept a **precertification** from the previous carrier or third-party administrator for the procedures, treatments, medications, or services covered by the benefits offered by the previous plan, including a **precertification** for behavior health or dental services from your previous Maryland Medical Assistance Program, for a period of 90 days or the course of treatment, whichever is less. If you are pregnant, you may continue the **precertification** for the duration of the three trimesters of your pregnancy and the initial postpartum visit.

Within 10 days of a request, the previous carrier or third-party administrator with the consent and at your or your parent, guardian designee or health care provider request shall provide a copy of the **precertification** to us.

We may elect to perform our own utilization review, once the time frames for treatment have expired in order to:

- Reassess and make its own determination regarding the need for continued treatment;
- Authorize any continued procedure, treatment, medication, or service determined to be medically necessary

### **Standing referrals**

We will issue you a standing **referral** to a network **specialist** if:

- Your **PCP**, in consultation with the **specialist**, decides you need continuing care from the **specialist**;
- You have a life threatening, degenerative, chronic, or disabling condition or disease; and
- The **specialist** has the expertise in treating your condition or disease

The standing **referral** should follow a written treatment plan developed by your **PCP**, the **specialist** and you. The treatment plan may limit number of visits and period. It may also require the **specialist** to communicate with your **PCP** regularly regarding your condition and treatment.

### **Referrals**

**Referrals** are not required for OB/GYN **network providers**.

### **Filing a claim**

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. We will send a claim form within 15 days of your request. If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss no later than 1 year after you have incurred expenses for covered benefits. We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us. You should always keep your own record of the date, **providers** and cost of your services.

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days of receipt of the claim. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back. You can refer to the *General provisions – other things you should know* section for more information on rescission.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, appeal procedures* section for that information.

## Adverse decisions

If we make an adverse decision on any non-emergency case, we will inform you, your representative or the **provider** orally by telephone or with affirmative consent from you, your representative or the **provider** acting on your behalf by text, fax, e-mail, online portal or other expedited means of the adverse decision. Within 5 working days of the date of the adverse decision, we will send a written notice to you, your representative and the **provider** acting on your behalf. The notice will include:

- The specific factual basis for the decision stated in clear, understandable language, and the reasoning used to determine that the health care service is not **medically necessary** and did not meet **Aetna's** criteria and standards used in conducting the utilization review.
- Provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the adverse decision was based, and may not solely use generalized terms or language directing the member to review the additional coverage criteria in the member's policy or plan document.
- The name, business address and business telephone number of the designated employee or representative of the plan who has responsibility for the internal grievance process and the physician who is required to make all adverse decisions.
- The details of the internal grievance process and procedures.
- A statement advising you, your representative or a **provider** acting on your behalf that they may, within 4 months of receiving the notice of a grievance decision (please refer to the "Level I – Filing a Grievance of an Adverse Decisions" section), file a complaint with the Maryland Insurance Commissioner. The contact information for the Maryland Insurance Commissioner also will be provided, including the Commissioner's address, telephone number and facsimile number.
- A statement advising you, your representative or a **provider** acting on your behalf that they may file a complaint with the Maryland Insurance Commissioner without first filing a grievance if:
  - We waive the requirement that its internal grievance process be exhausted before filing a complaint with the Maryland Insurance Commissioner;
  - We have failed to comply with any of the requirements of its internal grievance process as described herein; or
  - You, your representative or a **provider** acting on your behalf provides sufficient information and supporting documentation in the complaint that shows a compelling reason to do so. The "compelling reason" must show that the potential delay in receiving the health care service until after you, your representative or a **provider** acting on your behalf, has exhausted our internal grievance process and obtained a final decision, could result in:
    - Loss of life;
    - Serious impairment to a bodily function;
    - Serious dysfunction of a bodily organ;
    - You are remaining seriously mentally ill or using intoxicating substances with symptoms

- that cause you to be a danger to yourself or others; or
- You continue to experience severe withdrawal symptoms.

When filing a complaint with the Maryland Insurance Commissioner, you, your representative will be required to authorize the release of your medical records that may be required for the purpose of reaching a decision on the complaint.

The contact information for the Maryland Insurance Commissioner also will be provided.

In the case of a post-service adverse decision there is no compelling reason to bypass our internal grievance procedure and file a complaint with the Maryland Insurance Commissioner.

- A statement advising you, your representative or a **provider** acting on your behalf, that the Health Advocacy Unit:
  - Is available to help you with filing a grievance under the carrier’s internal grievance process;
  - Is not available to represent or accompany you during the procedures of the internal grievance process; and
  - Can help you in mediating a resolution of the adverse decision with the carrier, but that any time during the mediation, you, your representative or a **provider** acting on your behalf, may file a grievance.

The contact information for the Health Advocacy Unit also will be provided.

### **Level I – Filing a grievance of an adverse decision**

If after reviewing the information provided by us, you, your representative or a **provider** acting on your behalf wishes to have the adverse decision reconsidered, you, your representative or a **provider** acting on your behalf can file a grievance within the next 180 calendar days of receipt of the adverse decision. A grievance may be filed orally or in writing.

The grievance should contain sufficient information for us to investigate and render a decision. All grievances will be handled as described below.

The appropriate **Aetna** Grievance Unit will review all of the information submitted. It will gather any additional information necessary to prepare and render a decision about the grievance. If there is insufficient information available to make a decision, the Grievance Unit will notify you, your representative or a **provider** acting on your behalf of the need for additional information. This will occur within 5 working days of the filing date on the grievance. The Grievance Unit will help you, your representative or a **provider** acting on your behalf to obtain the information without further delay. If necessary for the review, it also will send an “authorization for release” form to you for the purpose of obtaining medical records or other information.

Except for an emergency case (please see “Expedited Review of Adverse Decisions”) our Grievance Unit will review and render a grievance decision within:

- 24 hours of the filing date of the request with respect to a claim involving an urgent medical condition;
- 15 calendar days of the filing date of the request with respect to a pre-service claim;
- 30 calendar days of the filing date of the request with respect to a post-service claim.

The Grievance Unit will orally communicate this grievance decision to you, your representatives or a **provider** acting on your behalf. A written notice stating the results of the review by the appropriate Grievance Unit will be forwarded to you, your representative and the **provider** acting on your behalf. This will occur within 5 working days of the date of the decision. This notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards, including interpretive guidelines, on which the

grievance decision was based.

- The name, business address and telephone number of the designated employee or representative of the plan who has responsibility for the internal grievance process and the physician who is required to make all adverse decisions
- If the adverse decision is upheld, a statement advising you, your representative or a **provider** acting on your behalf that they have the option of requesting a Committee Review as described in the “Level II – Committee Review” section, within the next 10 days after receipt of the notice.
- A statement advising you, your representative or a **provider** acting on your behalf that if they choose not to request the optional Committee Review, they have the right to file a complaint with the Maryland Insurance Commissioner, within 4 months after receipt of the grievance decision. The contact information, address, telephone number, and facsimile number for the Maryland Insurance Commissioner will also be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you, your representative in filing a complaint with the Maryland Insurance Commissioner. The contact information, address, telephone number, facsimile number, and electronic mail address for the Health Advocacy Unit will also be provided.
- A statement informing you about where this information can be found in the policy, enrollment materials or other evidence of coverage.

A complaint also may be filed with the Maryland Insurance Commissioner, using the contact information referenced above, if we do not render a grievance decision within 30 working days of the filing date of the pre-service grievance; and 45 working days of the filing date of the post-service grievance.

### **Level II – Committee review of a grievance decision**

You, your representative or a **provider** acting on your behalf may request a level II Committee Review to dispute a grievance decision. Level II Committee Reviews are voluntary. If you, your representative or a provider acting on your behalf decides not to request a Level II Committee Review, they still have the option of filing a complaint with the Maryland Insurance Commissioner. Please refer to the time periods specified in “Level I – Filing a Grievance of an Adverse Decision” section.

For grievances, the Level II process begins when you, your representative or a **provider** acting on your behalf, is not satisfied with the Level I grievance decision and requests, either orally or in writing, a Level II Committee Review. To request a Level II Committee Review, you, your representative or a **provider** acting on your behalf must request a Committee Review within 10 days from the date of oral notification of the Level I grievance decision. You, your representative or a **provider** acting on your behalf also must agree, in writing, to give us a 30 working day extension to render a final grievance decision.

Upon receipt of the request for a Level II Committee Review, we will provide you with the procedures governing Committee Reviews. You will be notified of your right to have an uninvolved **Aetna** representative available to help you in understanding the committee Review process.

A review body at the local market (hereinafter the: “Committee Review Panel”) will be formed to handle the Committee Review. The reviewers must not have participated in any prior review determinations. The composition of the review body must be peers of the treating health care **provider** (physician to physician; chiropractor to chiropractor). If the dispute involves a medically necessary, medically appropriate or medically efficient issue, they must be board certified or board eligible in a discipline pertinent to the issue under review; or a panel of other appropriate health care service reviewers with at least one physician on the panel board certified or board eligible in a discipline pertinent to the issue under review.

We will hold Committee Reviews in its offices as needed, but no more than 20 working days after the filing date of the Committee Review request. Written notification will be sent to you indicating the time; date; and

location; of the hearing.

In the event you are unable to attend the hearing on the scheduled hearing day, the dispute will be heard in your absence.

You will have the right to the following:

- Attend the Committee Review.
- Question our representative designated to appear at the review and any other witnesses.
- Present their case.
- Be assisted or represented by a person of your choice.
- Submit written material in support of their dispute.

You may bring a physician or other expert(s) to testify on your behalf. We will also have the right to present witnesses. Counsel for you may present your case and question witnesses, if you are so represented. Similarly, we also may choose to be represented by counsel. The Committee Review Panel will have the right to question our representative, you and any other witnesses.

The Committee Review will be informal. It will not apply formal rules of evidence in reviewing documentation or accepting testimony at the review. The Chair of the Committee Review Panel will have the right to exclude redundant testimony or excessive argument by any party or witness. A written record of the Committee Review will be made by a stenographic transcription. All testimony will be under oath.

Before the record is closed, the Chair of the Committee Review Panel will ask both you and our representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Committee Review Panel. Once all evidence and arguments have been received, the record of the Committee Review will be closed. The deliberations of the Committee Review Panel will be confidential and will not be transcribed.

The Committee Review Panel will render a written decision within 5 working days of the conclusion of the Committee Review.

For grievances, the written decision will contain:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards, including interpretive guidelines on which the grievance decision was based.
- The name, business address and telephone number of the medical director that made the grievance decision.
- A statement that a list of individuals participating in the review of the dispute, along with their titles and credentials is available upon written request.
- A statement of the reviewers understanding of the pertinent facts of the dispute.
- A reference to the evidence or documentation used as the basis for the decision.
- A statement advising you, your representative or a **provider** acting on your behalf that they have the right to file a complaint with the Maryland Insurance Commissioner, within 4 months after receipt of the grievance decision. The contact information for the Maryland Insurance Commissioner will also be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you, your representative in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit will also be provided.

### **Expedited review of adverse decisions**

You, your representative or a **provider** acting on your behalf may request an expedited review when an adverse decision is rendered for health care services that are proposed but have not been delivered. The services must be necessary to treat a condition or illness that, without immediate medical attention, would:

- Seriously jeopardize your life or health or your ability to regain maximum function;
- Cause you to be a danger to yourself or others; or
- Cause you to continue using intoxicating substances in an imminently dangerous manner.

You, your representative or a **provider** acting on your behalf will be notified immediately if we do not have sufficient information to complete the expedited review and we will help you, your representative or a **provider** acting on your behalf in gathering the necessary information without further delay.

Expedited reviews will be completed within 24 hours of the time you, your representative or a **provider** acting on your behalf initiates the request. You may file a complaint with the Maryland Insurance Commissioner if the expedited review is not completed within 24 hours of the request.

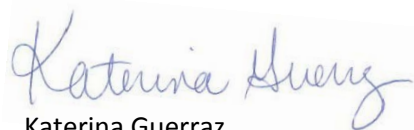
Within 1 day after a decision has been orally communicated to you, your representative or a **provider** acting on your behalf, a written notice will be sent to you, your representative and the **provider** acting on your behalf. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language.
- A reference to the specific criteria and standards, including interpretive guidelines on which the expedited review was based.
- The name, business address and telephone number of the medical director that made the expedited review.
- A statement informing you, your representative or a **provider** acting on your behalf that they have the right to file a complaint with the Maryland Insurance Commissioner, within 4 months of receipt of the grievance decision. The contact information for the Maryland Insurance Commissioner will also be provided.
- A statement advising you that the Health Advocacy Unit is available to assist you, your representative in filing a complaint with the Maryland Insurance Commissioner. The contact information for the Health Advocacy Unit will also be provided.

If the expedited review is a concurrent review determination, the service should be continued without liability to you until you are notified of the decision. This does not apply if the service is related to an initial unauthorized admission.

Expedited reviews for retrospective non-certifications are not required.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Maryland Medical ET

Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 unless the benefits in your booklet-certificate are better.

### Antineoplastic therapy prescription drugs

**Eligible health services** include **prescription** drugs used in antineoplastic therapy and its administration.

**Covered services** also include any FDA-approved **prescription** drugs regardless of whether the neoplasm the **prescription** drug is treating is the same neoplasm the FDA approved the **prescription** drug for, if all of the following conditions are met:

- Your **physician** orders the **prescription** drug for the treatment of a specific type of neoplasm
- The FDA approves the **prescription** drug for use in antineoplastic therapy
- The **prescription** drug is used as part of an antineoplastic drug regimen
- Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment
- You give your **physician** consent for the treatment regimen, which includes FDA-approved **prescription** drugs for off-label indications

The following are not **covered services** under your plans:

### Abortion

Services and supplies provided for an abortion except when the pregnancy places for woman's life in serious danger.

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

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

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

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

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

**Important note:**

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

### **Surprise bill**

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may 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** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles, copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers

- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

Prior to obtaining your consent, your provider or facility should also provide to you a “good faith” estimate of your expected billing.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

### **Provider Directories and Provider Networks**

Our network of doctors, hospitals and other health care providers is there to give you the care you need. You can find network providers and see important information about them most easily on our online provider directory. The most up-to-date directory for your plan appears at [www.aetna.com](http://www.aetna.com). You can also contact us by calling Aetna Member Services at the toll-free number on your ID card.

If you relied on inaccurate information from our provider directories or website or that we verbally provided, we hold you harmless. For example, if you received services from a provider that you believed was in-network based on inaccurate information showing that the provider was in-network, but your claim was paid as **out-of-network**. In these situations, contact us – we’re here to help. The number is on the back of your ID card. We will review the claim. After review you may be responsible only for your in-network cost share.

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

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

### **Adding new dependents**

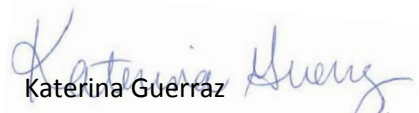
You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

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

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date. A newborn child is covered from the moment of birth.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Michigan Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Applied behavior analysis

**Covered services** include applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

### Autism spectrum disorder

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

**Covered services** include, but are not limited to, the services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder
- Neurodevelopmental and behavioral health treatment and management
- Medications (covered under your pharmacy benefit)

The diagnosis, evaluation, and assessment must include an assessment of your developmental skills, functional behavior, needs, and capacities.

We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of an individualized treatment plan. We may request an updated treatment plan only once every six months unless we and the treating **physician** or **behavioral health provider** agree a more frequent review is necessary.

### Cleft lip and cleft palate

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

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

Under this provision, if orthodontic treatment serves are eligible for coverage under a dental insurance plan and this plan, the dental plan is primary and this plan is secondary.

## Clinical trials

### Routine patient costs

**Covered services** include routine patient costs 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.

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”

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

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

## Dental care anesthesia

**Covered services** include anesthesia if you:

- Are a child under age 5

- Are severely disabled
- Have a medical condition and requires hospitalization or general anesthesia for dental care treatment

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** under this certificate.

## 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

For more information on **precertification**, including the criteria used in making coverage decisions and limitations pertaining to **DME**, see the *Contact us* section.

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

## 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:

- You are homebound
- Your **physician** 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 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
- Medical social services are provided by or supervised by a **physician** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are ventilator dependent, **covered services** also include 120 hours of services by a home care nurse or personal care assistant during the time you are in a **hospital**. The personal care assistant or home care nurse shall only perform the services of communicator or interpreter for you to assure adequate training of the **hospital** staff to communicate with you and to understand your unique comfort, safety, and personal care you needs.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

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

## **Jaw joint disorder treatment**

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

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

Coverage will be the same as treatment to any other joint in the body when administered or prescribed by a physician or dentist.

## **Lyme disease treatment**

**Covered services** include the diagnosis and treatment for Lyme disease.

## **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 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, but are not limited to: (covered under your pharmacy benefit)

- Behavioral therapies to manage neuropsychiatric symptoms
- Plasma exchange
- Immunoglobulin
- Antibiotics and medications (covered under your pharmacy benefit)

### **Port wine stain elimination**

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

### **Private duty nursing – in-home / outside-home**

**Covered services** include private duty nursing services in your home when you are covered by both this health plan and are also enrolled in Medicaid and when prior authorized. If you are authorized to receive these services in your home, you may use approved hours outside the home during hours when normal life activities take you outside of your home. All private duty nursing services must be provided according to the limits established under Medicaid rules.

The following are not **covered services**:

- Inpatient private duty nursing care, unless you are an authorized ventilator-dependent recipient in a hospital or you are otherwise eligible and are on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used.
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

### **Anti-cancer drugs taken by mouth**

**Covered services** include any drug prescribed for cancer treatment, including chemotherapy drugs. 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** than what is required for intravenous or injected cancer medications that are used to kill or slow the growth of cancerous cells.

### **Anti-psychotic prescription drugs**

**Covered services** include antipsychotic **prescription** drugs prescribed to treat an emotional disturbance or **mental health disorder**, regardless of whether the drug is listed in the **drug guide**, if the prescribing **provider**:

- 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 **drug guide** and determined that the drug prescribed will best treat your condition

We will not provide coverage for a drug if the drug was removed from the **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 **drug guide**
- Require written certification each time the **prescription** is refilled or renewed

In addition, if the **prescription** drug used to treat the **mental health 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 **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 prescribing **provider** 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 prescribing **provider** re-indicates dispensed as communicated
- Renews the certification with us

We will grant a medical exception to the **drug guide** when the prescribing **provider** indicates that the:

- **Drug guide prescription** drug
  - Caused an adverse reaction
  - Is contraindicated for you
- **Prescription** drug must be Dispensed as Written (DAW) to provide maximum medical benefits to you

## **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.

**Covered services** also include scalp hair prostheses (wigs) for hair loss resulting from a health condition, including, but not limited to, alopecia areata and the treatment for cancer, including necessary equipment and accessories.

Coverage includes:

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

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

The following are not **covered services**:

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

### **Child health supervision services**

**Covered services** include child health supervision services such as:

- Pediatric preventive services
- Appropriate immunizations from ages 6 to 18
- Developmental assessments
- Laboratory services appropriate to a child up to age 6

See the schedule of benefits for more information.

### **Routine cancer screenings**

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms, including digital breast tomosynthesis if you are at risk for breast cancer and any supplemental diagnostic services or testing for cancer after initial mammogram
  - 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
- Ovarian cancer surveillance tests if you are at risk for ovarian cancer
  - Tests include:
    - CA-125 serum tumor marker testing
    - Transvaginal ultrasound
    - Pelvic examination
    - Other proven ovarian cancer screening tests currently being evaluated by the FDA or the National Cancer Institute
  - At risk for ovarian cancer is any of the following:
    - Having a family history of:
      - One or more first or second degree relatives with ovarian cancer
      - Clusters of women relatives with breast cancer

- Nonpolyposis colorectal cancer
      - Testing positive for BRCA1 or BRCA2 mutations
- Prostate specific antigen (PSA) tests
  - The screening must consist at a minimum of a PSA blood test and a DRE if you are either:
    - Younger than age 50, but are symptomatic or considered to be at high risk
    - Age 50 or older
- Sigmoidoscopies

## Reconstructive breast surgery and supplies

**Covered services** include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting, in a manner determined in consultation with the **provider** and you, only in the following circumstances:

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

**Covered services** may be subject to the annual **deductible**, **copayment** or **coinsurance** and are consistent with other benefits under the plan.

## Reconstructive surgery and supplies

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

- Your **surgery** is incidental to or follows **surgery** resulting from injury, illness, or other diseases of the body part involved
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects an anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in facial disfigurement or functional impairment of a body part, and
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in facial disfigurement or functional impairment of a body part, and your **surgery** will improve function.
- Your covered dependent child's **surgery** is needed due to a congenital disease or anomaly which resulted in functional defect, as determined by their **provider**.

## Accidental injury to natural teeth

**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 accident-related dental 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

## Diagnostic lab work

**Covered services** include:

- Lab
- Pathology

- Other tests

### **Biomarker testing**

Biomarker testing is the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to:

- Single-analyst tests
- Multiplex panel tests
- Protein expression
- Whole exome sequencing
- Whole genome sequencing
- Whole transcriptome sequencing

A biomarker is a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include, but are not limited to:

- Gene mutations
- Characteristics of genes
- Protein expression

Clinical utility is a test providing information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

**Covered services** include biomarker testing to diagnose, treat, manage and monitor your illness or disease when the test provides clinical utility. A test's clinical utility may be demonstrated by medical and scientific evidence as set forth by Minnesota law.

Coverage is provided in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples.

### **Rapid whole genome sequencing (rWGS)**

Rapid whole genome sequencing is an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. This includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

**Covered services** include rWGS if you:

- Are 21 years of age or younger
- Have a complex or acute illness of unknown etiology that is not confirmed to have been caused by any of the following:
  - Environmental exposure
  - Toxic ingestion
  - Infection with a normal response to therapy
  - Trauma
- Are receiving inpatient **hospital** services in an:
  - Intensive care unit
  - Neonatal care unit
  - High acuity pediatric care unit

Coverage may be based on the following **medically necessary** criteria:

- You have symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rWGS testing is not performed
- Timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS testing may aid in guiding the treatment or management of your condition
- Your complex or acute illness of unknown etiology includes at least one of the following conditions:
  - Congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system
  - Specific organ malformations that are highly suggestive of a genetic etiology
  - Abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism
  - Refractory or severe hypoglycemia or hyperglycemia
  - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems
  - Severe muscle weakness, rigidity, or spasticity
  - Refractory seizures
  - A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:
    - A recurrent event without respiratory infection
    - A recurrent seizure-like event
    - A recurrent cardiopulmonary resuscitation
  - Abnormal cardiac diagnostic testing results that are suggestive of possible:
    - Channelopathies
    - Arrhythmias
    - Cardiomyopathies
    - Myocarditis
    - Structural heart disease
  - Abnormal diagnostic imaging studies that are suggestive of underlying genetic condition
  - Abnormal physiologic function studies that are suggestive of an underlying genetic etiology
  - Family genetic history related to the patient's condition

To find out how much you will pay for rWGS services, see *Diagnostic lab work* in your schedule of benefits.

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

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

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

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

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

You may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

You'll be able to receive transitional care from your **provider** for a period up to 120 days for one or more of the following conditions:

- An acute condition
- A chronic condition
- A life-threatening mental or physical illness

- Pregnancy
- A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or result in death
- A disabling or chronic condition that is in an acute phase

Transitional care from your **provider** may extend to the remainder of your life if a **physician** or **health professional** certifies that your life expectancy is 180 days or less.

If this situation applies to you, contact us for details. As long as the **provider** didn't leave the network based on fraud or lack of quality standards, or group termination of loss of benefits with the **provider**, you'll be able to receive transitional care from your **provider** for a period up to 120 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

**Important note:**

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

**Surprise bill**

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may 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** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including-:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services-
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings-

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

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

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

## External review

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

You have a right to external review only if:

- You have received an adverse benefit determination

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

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

You must submit the request for external review form:

- To the Minnesota Department of Commerce:
  - Write them at 85 7<sup>th</sup> Place East, Suite 280, St. Paul, MN 55101
  - Recommended: Email the form to [consumer.protection@state.mn.us](mailto:consumer.protection@state.mn.us)
  - Call the Commerce Department's Consumer Services Center at (651) 539-1600 or (800) 657-3602 and speak with an insurance investigator

- Visit <https://mn.gov/commerce/consumer/file-a-complaint/> for more information
- Within 6 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Minnesota Department of Commerce 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 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 ability to regain maximum function
  - 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 a delay in 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.

### **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:
  - o Under 26 years of age
- Dependent children include:
  - o Natural children
  - o Stepchildren
  - o Adopted children including those placed with you for adoption
  - o Foster children
  - o Children you are responsible for under a qualified medical support order or court order
  - o Grandchildren in your legal custody
  - o Grandchildren financially dependent upon you and who reside with you continuously from birth
  - o A grandchild whose parent is already covered as a dependent on this plan

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

Your coverage may be extended if you are totally disabled when coverage ends. You are “totally disabled” if you cannot work at your occupation within the first 2 years of your disability or you cannot work at your own occupation or any other occupation for pay or profit after 2 years of disability.

Your covered dependent is “totally disabled” if they are incapable of self-sustaining employment due to developmental disability, mental illness or disorder, or physical disability, and depends mainly on you for support and maintenance.

You may extend coverage until the earliest of:

- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan

**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, and
- Payment is made for coverage

To request extension of coverage, the dependent, or their representative, should contact us within 90 days after your death.

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

- The date coverage would otherwise end under the policy or plan had you lived
- They become covered by another health benefits plan

Your dependents may be required to pay the entire cost to extend coverage and benefits. Premium costs may be up to 102% of the cost of the plan, but will not exceed that amount. Failure to make premium payments within 90 days after notice of the requirement to pay the premiums is a basis for terminating your coverage without written consent. We will mail a written notice to your dependent’s last known address at least 30 days before we end the coverage for failure to pay premium payments.

Any required premiums should be paid by the dependents to the policyholder to send to us.

To request extension of coverage, the dependent, or their representative, can contact us.

### **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 will be considered to be laid off from employment if there is a reduction in hours to the point where you are no longer eligible under the policy or plan.

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
- You or your dependents 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 dependents 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
- The date dependent coverage would otherwise end under the policy
- 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.

### **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.

### **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 or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, must help restore or maintain your health or prevent deterioration of your condition, and that are all of the following, as determined by us within our discretion:

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

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

**Important note:**

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.

## Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

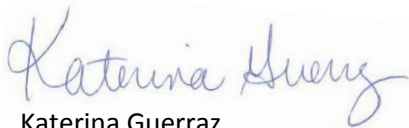
A **PCP** can be any of the following **providers**:

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

## 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.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Minnesota Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 unless the benefits in your booklet-certificate are better.

### Retail Pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs.

### Time of payment of claims

1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A “clean claim” means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

A clean claim does not include any other the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or
- d. Claims submitted by a provider more than thirty (30) days after the date of services; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more

than thirty (30) days after the date of billing by the provider to the insured.

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 clean 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 United 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 sent 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. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance. The Commissioner of Insurance shall adopt any rules and regulations necessary to enforce these provisions regarding assignment of benefits and billing.

## **Complaints, claim decisions and, appeal procedures**

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### **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**

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### **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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

### **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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

#### **Any other claim appeal**

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 contacting us. You need to include:

- Your name
- The plan sponsor's name
- A copy of the adverse benefit 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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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.

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

You must submit the request for external review form:

- To the Mississippi Insurance Department
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The State 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 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 ability to regain maximum function
  - 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 a delay in 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.

### **Utilization review**

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

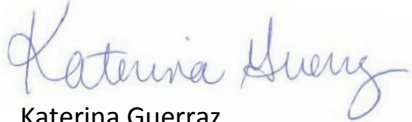
### **Recordkeeping**

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.

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Mississippi Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

- The screening, diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

### 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
  - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

### Hearing aids for covered dependent children under age 19

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

For a covered dependent child under age 19 years, **covered services** include replacement of a hearing aid and associated services within 3 months if:

- The gain and output fail to meet the prescribed targets
- It is unable to be repaired or adjusted

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

### **Anti-cancer drugs taken by mouth and drugs to treat human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)**

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

### **Preventive care immunizations**

No deductible applies to immunizations for dependent children to age 6.

### **Routine cancer screenings**

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms, including:
  - One baseline mammogram for women between ages 35 and 40
  - One mammogram every 2 years for women between ages 40 and 49
  - One mammogram every year for women age 50 and older
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

# Complaints, claim decisions and appeal procedures

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## 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 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

### Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

## 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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete the first level before you can take any other actions, such as an external review.

## 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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### Any other claim appeal

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 contacting us. You need to include:

- Your name
- The plan sponsor’s name
- A copy of the adverse benefit 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 15 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 first level of appeals with us before you can take these other actions. The second level of appeal is always voluntary:

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

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

Sometimes you do not have to complete either of 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 the federal Department of Health and Human Services. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental or investigational**

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

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

external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To the Nebraska Department of Insurance
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

Nebraska Department of Insurance will contact the IRO that will conduct the review of your claim.

The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

### **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 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 ability to regain maximum function
  - 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 a delay in 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.

## **Utilization review**

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

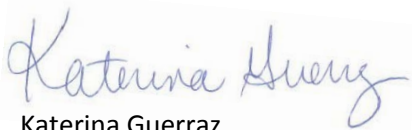
### **Recordkeeping**

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.



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Nebraska Medical ET

Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 unless the benefits in your booklet-certificate are better.

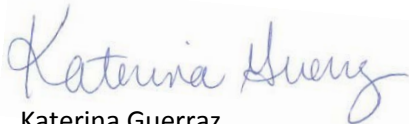
The following has been added to or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate.

### 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.



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: New Jersey Medical ET

Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Pridestaff, Inc.  
**Group policy number:** GP-0805902  
**Amendment effective date:** January 01, 2026

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 Nevada. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### 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

### 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 15 days.

**Post-service claim**

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

**Concurrent care claim extension**

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

**Concurrent care claim reduction or termination**

If we believe a reduction or termination is justified for an already approved course of treatment we will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

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

## Complaints, claim decisions and appeal procedures

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### 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

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### 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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

If we make an adverse benefit determination, we will tell you in writing within 10 business days of our decision. The notice will include information on your right to appeal our 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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

#### Any other claim appeal

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 contacting us. You need to include:

- Your name
- The plan sponsor’s name
- A copy of the adverse benefit 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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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 Office for Consumer Health Assistance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Office for Consumer Health Assistance
- 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 Nevada. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To the Office for Consumer Health Assistance
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

Office for Consumer Health Assistance  
3300 W. Sahara Avenue, Suite 100  
Las Vegas, NV 89102  
Hours: Monday- Friday 8:00 am to 5:00 pm  
Phone: (702)486-3587 or Toll Free 1-888-333-1597  
Fax: (702) 486-3586  
Email: cha@govcha.state.nv.us

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

The Office for Consumer Health Assistance will contact the IRO that will conduct the review of your claim.

The IRO 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

The Office for Consumer Health Assistance will notify you, your representative and us that they have received the request for external review within 5 days after they receive the request.

Once the Office for Consumer Health Assistance notifies us of the assigned IRO, we will provide to them all of the necessary information relating to the determination, within 5 days.

After the IRO receives the required documentation from us, they will notify you or your representative if they need additional information to conduct the review. The additional information must be submitted within 5 days after the request is received. The IRO will forward the information to us within 1 business day after they receive it.

The IRO will make its determination to approve, modify or reverse the adverse determination within 15 days after it receives all the information it needs to make the determination.

The IRO will submit a copy of their determination, including the reasoning for the decision, to:

- You
- Your **physician**
- Your authorized representative, if any
- Us

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

### **How long will it take to get an IRO decision?**

The IRO will provide their determination to you in a timely manner according to the timeframe necessary to obtain the required information.

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 ability to regain maximum function
  - 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 a delay in 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)
- 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 requires an expedited external review, you may submit that request to the Office for Consumer Health Assistance. They will approve or deny the request within 72 hours after they receive it.

If approved, the request will be submitted to the IRO no later than 1 business day from the approval.

We will submit all relevant medical documentation and information used to establish the adverse determination within 24 hours after we receive the notice from the Office for Consumer Health Assistance.

The IRO will complete the expedited review within 48 hours after they are assigned the case unless you, your representative, if any, and we agree to a longer period of time.

The IRO will send notification of its decision within 24 hours after completing its review, to:

- You
- Your **physician**
- Your authorized representative, if any
- Us

The IRO will submit a written copy of its determination within 48 hours to the parties listed.

### **Utilization review**

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

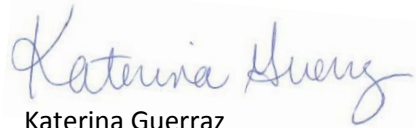
### **Recordkeeping**

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.

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Nevada Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### **N. Protection from Surprise Bills.**

**Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (“IDRE”) assigned by the state. The IDRE will determine whether Our payment or the Provider’s charge is reasonable within 30 days of receiving the dispute.

## SECTION VIII

### Emergency Services

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

#### A. Emergency Services.

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

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

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

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

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

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

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

- 1. Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department. We do not**

**Cover follow-up care or routine care provided in a Hospital emergency department.**

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

We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the In-Network Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

- 3. Payments Relating to Emergency Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services.

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

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

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

**C. Conversion Therapy.**

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

**Continuation of Coverage**

**C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.**

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Policy through the age of 29 if he or she:

1. Is under the age of 30;

2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

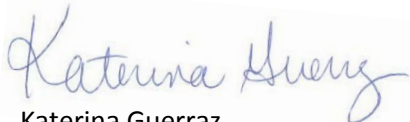
The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: New York Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Ohio. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a pediatrician, **physician** or **behavioral health provider**, including a psychologist trained in Autism spectrum disorder for:

- The screening, diagnosis, prescription drugs, and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

**Covered services** also include outpatient rehabilitation services, including physical, speech and occupational therapies, and clinical therapeutic interventions. Clinical therapeutic interventions are defined as therapies supported by empirical evidence that include, but are not limited to, applied behavioral analysis, provided by or under the supervision of a professional that is licensed, certified, or registered by an appropriate agency if Ohio to perform the services in accordance with a treatment plan. Please see your schedule of benefits for any benefit limitations.

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs 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.

**Covered services** also include routine patient care costs, including clinical trial therapies, if you are participating in any stage of an eligible cancer clinical trial as defined by state law and all of the following is met:

- The purpose of the trial is to test whether the intervention may improve the participant's health or the treatment is given with the intention of improving the participant's health, and is not designed to test toxicity or disease pathophysiology
- The trial does one of the following:
  - Tests how to administer and the responses to health care services, items, or drugs for

- cancer treatment
  - Compares the effectiveness of a health care service, item, or drug for cancer treatment
  - Studies new uses of health care services, items, or drugs for cancer treatment
- The trial is approved by one of the following:
  - The National Institutes of Health
  - The Food and Drug Administration
  - The Department of Defense
  - The Department of Veterans Affairs
  - 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
  - The Department of Energy

The following are not **covered services** under this section:

- 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)
- A health care service, item, or drug that is subject to the cancer clinical trial or is provided solely to satisfy data collection and analysis and not used in direct clinical management of the patient
- An investigational or experimental drug or device not approved for market by the FDA
- Transportation, lodging, food, or other expenses for the patient, family member, or companion that are associated with travel to or from a facility providing the cancer clinical trial
- An item or drug provided by the cancer clinical trial sponsors free of charge
- A service, item, or drug eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial
- Experimental or investigational treatment

## Maternity and related newborn care

**Covered services** include pregnancy (prenatal) care, care after delivery and obstetrical services. This would include coverage of **injury** or sickness and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. 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. The decision can be made by a certified nurse-midwife in collaboration with the attending **physician**.

**Precertification** is only required for maternity and newborn **stays** that exceed the standard length of **stay**.

If the mother is discharged earlier, **covered services** include post-delivery home visits for follow-up care for the mother and newborn when recommended, ordered and supervised by a health care **provider**, which includes a **physician** or advanced practice registered nurse. If the mother is discharged earlier than the minimum lengths of **stay**, **covered services** include all follow-up care received within 72 hours after discharge. If the mother receives at least the minimum number of hours of inpatient care, we will pay for **covered services** as recommended by the attending **physician**. The home visits include:

- Parent education
- Assistance training in breast or bottle feeding

- Physical assessment of the newborn and mother
- The collection of an adequate sample for the hereditary and metabolic newborn screening
- Clinical tests and other services that are in line with follow-up care recommended in the protocols and guidelines developed by national organizations representing the **providers**

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
- Surrogacy when the surrogate is not a covered person

### **Anti-cancer drugs taken by mouth**

**Covered services** include any drug prescribed for cancer treatment, including chemotherapy drugs. 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 will not be less favorable than for intravenously or injected anti-cancer prescription drugs.

### **Child Health Supervision Services**

Child Health Supervision Services include **covered services** for the periodic review of a child's physical and emotional status performed by a **physician, PCP** or other **health professional** from birth to age 9. A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics.

### **Mammography screening**

**Covered services** include the following routine cancer screening:

- Mammograms, including screening for women:
- Age 35-39, annually
- Age 40-49, every 2 years; or annually for women at increased risk for breast cancer as determined by your provider or health professional
- Age 50-64, every 2 years

#### **Mammograms received out-of-network important note:**

**The total amount payable by Aetna and you may not exceed 130% of the Medicare reimbursement amount. We will make the payment to your provider or facility in accordance to the plan. No provider shall seek or receive payment in excess of 130% of the Medicare reimbursement amount. Members can only be billed for deductibles, copayments and coinsurances.**

### **Precertification**

**Precertification** must be obtained for opioid analgesics for the treatment of chronic pain except when a drug is prescribed for an individual who is

- a hospice patient
- diagnosed with a terminal condition
- a cancer patient

### **External review**

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). This can be conducted by an ERO or by the Ohio Department of Insurance.

You have a right to external review when you have received an **adverse benefit determination**.

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

- You have received an **adverse benefit determination**
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

You must submit the request for external review form:

- Within 180 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

There are two types of ERO review, standard and expedited. A standard review is completed within 30 days. An expedited review for urgent medical situations is completed within 72 hours and can be requested of any of the following applies:

- The **provider** treating you can certify that the **adverse benefit determination** involves a medical condition and that it would do any of the following:
  - Seriously jeopardize your life or health
  - Jeopardize your ability to regain maximum function if treatment is delayed until the timeframe of an expedited appeal
  - Jeopardize your ability to regain maximum function if treatment is delayed until the timeframe of a standard external review
- The final adverse determination is for **emergency services** for an admission, availability of care, continued **stay**, or health care services and you have not been discharged from the facility
- The final adverse determination is for an experimental or investigational treatment and the **provider** treating you certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated

**Important note:**

An expedited external review is not available for health care services that you have already received. Requests for external reviews can be requested in writing, orally, or electronically.

### **External review with the Ohio Department of Insurance**

You have a right to a review from the Ohio Department of Insurance, only if:

- The claim decision did not involve a medical judgment or medical information
- The claim decision was already reviewed by an ERO and the ERO decided that your claim should not be paid
- Your claim was for an **emergency medical condition** determined not to meet the definition of **emergency services**
- And you have completed our internal appeal process

## What happens when we receive a request for external review?

When we receive the request for external review, we will:

- Verify the request is complete
- Notify you in writing of the following:
  - The name and contact information for the ERO or the Ohio Department of Insurance in case you want to submit additional information
  - The 10 day timeframe you have to submit additional information to the ERO or Ohio Department of Insurance

If after our review we conclude that we are missing information we will notify you in writing. This notice will indicate what specific information is needed to complete the request. If we determine that the **adverse benefit determination** is not eligible for an external review, we will notify you in writing, and:

- Provide you with the reason for the denial
- Inform you of your right to submit an appeal to the Ohio Department of Insurance

The Ohio Department of Insurance may determine that your request is eligible for an external review even if we did not. In that case, we will initiate the external review with the ERO.

## ERO review and decision

The ERO is not obligated to agree with any decisions or conclusions we made during our review or appeal process.

In order for the ERO to be able to make a decision, the ERO must consider:

- All the documents and information we submitted to them that were considered in making the adverse benefit decision
- Any information you submitted
- Other information, such as:
  - Your medical records
  - Your **provider's** recommendations
  - Any consulting reports from appropriate health care professionals
  - The term of coverage under this contract
  - The most appropriate practice guidelines
  - Clinical review criteria we might have used
  - The opinions of the ERO's clinical reviewers

## How long will it take to get an ERO decision?

The ERO will tell you of its decision within 30 days once we receive your request for a standard review or no later than 72 hours after the receipt of the request for an expedited review.

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

### Important note:

Once you file a request for an external review you cannot request another external review if it involves the same **adverse benefit determination** unless you submit new medical or scientific evidence to us.

## If you have questions about your rights or need assistance

You can contact us

You can also contact the Ohio Department of Insurance:

Ohio Department of Insurance

Attn: Consumer Affairs

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50 W. Town Street, Third Floor - Suite 300  
Columbus, OH 43215  
(614) 644-2658  
TDD: 614-644-3745  
614-644-3745 (TDD)  
(800) 686-1526  
[life.health.mcd@insurance.ohio.gov](mailto:life.health.mcd@insurance.ohio.gov)

Contact ODI Consumer Affairs:

<https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Comment.mvc/DisplayCommentSubmission>

File a Consumer Complaint:

<https://www.insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

## Adding new dependents

Your newborn child is covered on your health plan for the first 31 days from the moment of birth at no cost.

- Please notify us of the birth within 31 days.
- If your plan requires additional premium, we must receive notification within 31 days of your newborn’s birth to continue coverage
- If your coverage ends during this 31 day period, then your newborn’s coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

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

## Continuation of coverage - State of Ohio

### What are your rights?

Ohio law gives some people the right to keep their health coverage for 12 months after active employment ends. To be eligible for this continuation of coverage:

- You must have been employed for three consecutive months immediately before coverage ended
- You could not have voluntarily ended your employment
- Your employment could not have ended for gross misconduct
- You cannot be covered or eligible for any other group plan, Medicare, or COBRA

### When do I receive continuation information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

#### Employer/Group health plan notification requirements

Notice	Requirement	Deadline/Method
General notice - Aetna	Notify you and your dependents of continuation rights	Through this certificate
Notice of qualifying event – employer or Aetna	Your active employment ends for reasons other than gross misconduct	At the time the employer notifies you of your loss of employment

### How do you enroll?

You enroll by sending in an application and paying the **premium**. The application will tell you how to enroll and how much it will cost.

### When is your first premium payment due?

Your first **premium** payment must be made:

- Within 31 days from your employment termination date
- Within 10 days if your employer notified you of your loss of employment before your employment termination date
- Within 10 days if your employer notified you of your right to continue coverage after your employment termination date

### **How much will this coverage cost?**

You and your dependents will pay a monthly premium of 100% of the total plan costs

### **When does coverage end?**

Coverage ends if:

- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may be continued under the new plan
- You and your dependents fail to make the necessary payments on time
- You or a covered dependent become entitled to benefits under Medicare
- You or a covered dependent becomes covered under another plan

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

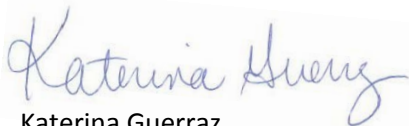
You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

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

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Ohio Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Oklahoma. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Mammograms

Mammography screening is not subject to **deductible, copayment, or coinsurance**, if any applies under the plan.

**Covered services** include the following:

- One mammogram every five years for a woman age 35-39
- One mammogram per calendar year for a woman age 40 or older

### Prescription Drugs

Up to a 90 day supply of prescription drugs may be obtained from a retail or mail order drug pharmacy.

### Abortion

Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger

### Abortion drugs

Drugs used for elective termination of pregnancy except when the pregnancy places the woman's life in serious danger

### Maximum coinsurance differential for network plans

In no event will the covered amount for In-Network charges exceed more than 30% of the covered amount for Out-of-Network charges.

### Filing a claim

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

**providers** and cost of your services.

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 45 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and appeal procedures* section for that information.

## **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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### **Any other claim appeal**

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 contacting us. You need to include:

- Your name
- The plan sponsor's name
- A copy of the adverse benefit 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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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 Oklahoma Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Oklahoma Department of Insurance
- Appeal through an external review process
- Pursue 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 Oklahoma or the federal Department of Health and Human Services. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

You must submit the request for external review form:

- To the Oklahoma Insurance Commissioner
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Oklahoma Insurance Commissioner will select an approved ERO that will conduct the review of your claim

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

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 ability to regain maximum function
  - 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 a delay in 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.

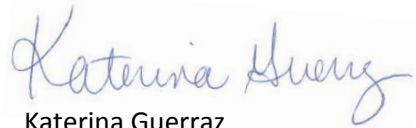
### **Recovery of overpayments**

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.

After the payment is made, we must request the overpayment from you within 12 months or from your **provider** within 18 months, except in cases:

- Of fraud
- When you or your health care **provider** agreed to refund us for the overpayment of a claim

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

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive, flowing style.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Oklahoma Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Oregon. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Ambulance services

An ambulance is a vehicle staffed by medical personnel and is equipped to transport an ill or injured person by ground, air, or water.

### Emergency

**Covered services** include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first can't provide the **emergency services** you need

### Non-emergency

**Covered services** also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance

The following are not **covered services**:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

## Clinical trials

### Routine patient costs

**Covered services** include routine patient costs 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.

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 cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- It is determined that you may benefit from the treatment

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

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

### 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

**Covered services** also include:

- Newborn nurse home visits as required by law for covered newborns
- **Prescription** drugs and supplies for managing diabetes during your pregnancy and 6 weeks after delivery.

**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

## Prosthetic device

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

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

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

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

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

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

### Important note:

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

## 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

Assistive hearing device means:

- Devices used to improve your ability with hearing loss in situations such as:
  - Being located a distance from a speaker
  - In an environment with competing background noise
  - In a room with poor acoustics or reverberation.

**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
- Bone conduction sound processors
- Bilateral cochlear implants
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

## Domestic Partners

You can enroll the following family members:

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

## Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may 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** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles, copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology

- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

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

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

## Complaints, claim decisions and appeal procedures

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### The difference between a complaint or grievance and an appeal

#### Complaint or grievance

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

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

### 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. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

### 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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

#### Any other claim appeal

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 contacting us. You need to include:

- Your name
- The plan sponsor’s name
- A copy of the adverse benefit 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.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision. We will notify you within 7 days once your appeal has been received.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. An authorized representative is a person who by law or with your consent may act on your behalf. 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 your member 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.

You have a right to file a complaint or seek other assistance from the Division of Financial Regulation.

Assistance is available:

- By calling 503-947-7984 or the toll-free message line 888-877-4894
- By electronic mail at: [DFR.InsuranceHelp@dcb.oregon.gov](mailto:DFR.InsuranceHelp@dcb.oregon.gov)
- By writing the Division of Financial Regulation, Consumer Advocacy at:
  - PO Box 14480, Salem, OR 97309-0405; or through the Internet at [dfr.oregon.gov/help](http://dfr.oregon.gov/help)

Your coverage for the service or supply will continue until you receive a final appeal decision from us.

You have a right to receive free of charge reasonable access to and copies of all documents, records and other information relevant to your appeal.

## **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 Oregon Department of Insurance, Consumer Protection Unit to request an investigation of a complaint, grievance or appeal
- File a complaint or appeal with the Oregon Department of Insurance, Division of Financial Regulation, Consumer Protection Unit
- 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 the federal Department of Health and Human Services. But you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- The service or supply is not **medically necessary**, not appropriate, or the service or supply is **experimental, investigational, or unproven**
- A course or plan of treatment that you are undergoing is denied as not an active course of treatment for the purposes of continuity of care
- The care is not delivered in an appropriate health care setting or the appropriate level of care

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

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

You must submit the request for external review form:

- To Aetna
- Within 180 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review. You will need to authorize us to release medical records the ERO may need for their review.

We will:

- Notify the Oregon Division of Financial Regulation that an external review request has been received within 2 business days of receiving your request
- Notify you within 24 hours after the date of a reversal if we reverse the final determination before the expiration of the 2 business days
- Send information to the ERO within 5 business days from the date of on which we receive the assigned ERO from the Oregon Division of Financial Regulation

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 30 calendar days of the date they receive your request form and all the necessary information

You may send additional information to the ERO within 5 business days of the selection of the ERO or 24 hours if you request a faster review.

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 30 calendar days after they 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 ability to regain maximum function
  - 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 a delay in 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.

### **Utilization review**

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

### **Recordkeeping**

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

### **Fees and expenses**

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to Aetna. We are responsible for the cost of sending this information to the ERO and the cost of the external review.

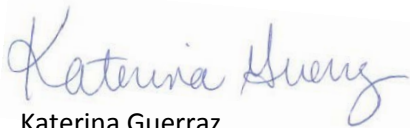
**Important note:**

- **You have the right to external review**
- **Aetna will be bound by the decision of the ERO, and may be penalized by the Department of Consumer and Business Services if it fails to do so**
- **You have the right to sue Aetna if the decision of the ERO is not implemented**

**The following additional information is available to you upon request:**

- **An annual summary of grievances and appeals**
- **An annual summary of utilization review policies**
- **An annual summary of quality assessment activities**
- **The results of all publicly available accreditation surveys**
- **An annual summary of scope of network and accessibility of service**

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Oregon Medical ET  
Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Dental care anesthesia

**Covered services** include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** as described in the *Coverage and exclusion* section.

### 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 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

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**.

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 you must try one or more prerequisite drugs before a **step therapy** drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the **step therapy** drug may not be covered. This requirement does not apply to stage four advanced metastatic cancer drugs.

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

### **Requesting a medical exception**

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

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

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

### **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. . There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

### **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. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for

a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### **Any other claim appeal**

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 contacting us. You need to include:

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

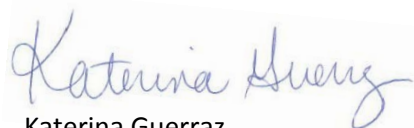
We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. Urgent care claims receive one level of appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal 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 your member 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.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Pennsylvania Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

---

**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

For mastectomy, 48 hour of inpatient care in a network hospital. In case of early discharge, one home visit if ordered by your attending physician.

### 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

**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

### Reconstructive breast surgery and supplies

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

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

Unless you and your **provider** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include 48 hours of inpatient care following a mastectomy. If you and your **provider** agree to a shorter time period, 1 home visit will be provided.

### **Continuation of coverage for other reasons**

#### **How you can extend coverage if you are totally disabled when coverage ends**

Your coverage may be extended if you are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension. You are “totally disabled” if you cannot work at your occupation or any other occupation for pay or profit.

Your covered dependent is “totally disabled” if they can’t engage in most normal activities like a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

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

### **Continuation of coverage under South Carolina law**

You may continue coverage for the remaining of the month in which your coverage ended plus an additional 6 months if:

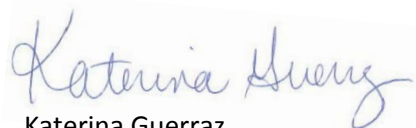
- You have been continuously covered under this plan for at least 6 months before it was ended
- The plan was ended due to any reason other than nonpayment of the premium, and
- You are not eligible for:
  - Other group coverage that provides similar benefits
  - Medicare benefits
  - COBRA

Upon termination, the contract holder will notify you of your right to continue coverage and the amount of your premium. You need to send the application within 30 days after the qualifying event.

Continuation of coverage ends if:

- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may be continued under the new plan
- You fail to make the necessary payments on time
- You become covered under another group health plan that provides similar benefits
- You become entitled to benefits under Medicare

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: South Carolina Medical ET

Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

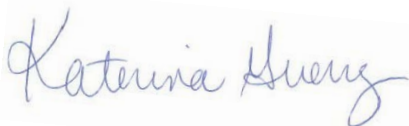
- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

### 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

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: South Dakota Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs 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.

The following are not **covered services**:

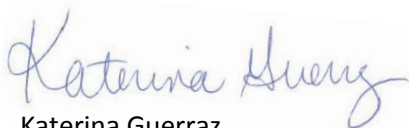
- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions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

Participation in a clinical trial will not be the sole reason to deny coverage.

### 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.



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company

(A Stock Company)

Amendment: Tennessee Medical ET  
Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 unless the benefits in your booklet-certificate are better.

**Important note:**

**Your rights with a preferred provider benefit plan (PPO)**

Notice from the Texas Department of Insurance

**Your plan**

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

**Your plan's network**

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

**If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at [www.tdi.texas.gov](http://www.tdi.texas.gov) or by calling 800-252-3439.**

**Health care costs**

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

**List of doctors**

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at [www.aetna.com](http://www.aetna.com) or by calling Aetna Member Services at the toll-free number on your ID card.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

### **Health care bills**

If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at [www.tdi.texas.gov](http://www.tdi.texas.gov).

## **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](http://www.aetna.com)

Email: [aetnamemberservices@aetna.com](mailto:aetnamemberservices@aetna.com)

Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711- 2030

## **¿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](http://www.aetna.com)

Correo electrónico: [aetnamemberservices@aetna.com](mailto: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](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711- 2030

## Preferred Provider Disclosure Notice

- You have the right to an adequate network of preferred **providers** (also known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
  - If you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network **deductible** and out-of-pocket maximum.
- You have the right, in most cases, to obtain estimates in advance:
  - from **out-of-network providers** of what they will charge for their services; and
  - from your insurer of what it will pay for the services.
- You may obtain a current **directory** of preferred **providers** at the following website: [www.aetna.com](http://www.aetna.com) or by calling **Aetna** Member Services at the toll-free number on your ID card for assistance in finding available preferred **providers**. If the **directory** is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
- If you are treated by a **provider** or **hospital** that is not a preferred **provider**, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network **hospital**-based radiologist, anesthesiologist, pathologist, emergency department **physician**, neonatologist, assistant surgeon, out-of-network emergency care **provider** or any out-of-network **provider** working at a network facility is greater than \$500 (not including your **copayment**, **coinsurance**, and **deductible** responsibilities) for services received in a network **hospital**, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: [www.tdi.texas.gov/consumer/cpmmediation.html](http://www.tdi.texas.gov/consumer/cpmmediation.html).

**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**

## 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 TRICARE military health system.

You can also receive treatment from someone working under the supervision of a **provider** as described above. As used here, “generally recognized services” can include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Physical therapy
- Occupational therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

## Behavioral health

### Mental health treatment

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

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

- Skilled behavioral health services provided 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 **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** or **telehealth** consultation)

**Covered services** will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

### **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**.
- 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** or **telehealth** 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**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** or **telehealth** consultation)

**Covered services** will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

**Behavioral health important note:**

The plan will not impose quantitative or nonquantitative treatment limitations on benefits for **mental health disorders** or **substance related disorders** that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

**Behavioral health important note:**

A peer support specialist serves as a role model, mentor, coach, and advocate. A peer support must be supervised by a **behavioral health provider**.

## 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 of Defense or the Department Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
    - The Food and Drug Administration
    - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

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 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:

- 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 the institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- 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

### **Dental care services and anesthesia in a hospital or surgery center**

**Covered services** include anesthesia and facility costs for dental care. Your **provider** must certify that the dental care cannot be performed in the dentist’s office due to a physical, mental, or medical condition.

The following are not **covered services**:

- The related dental services unless specifically listed as a **covered service** in this certificate.

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

**Covered services** include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Insulin and insulin analog preparation
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Injection devices including syringes, needles and pens
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Diabetic test agents, including but not limited to, visual reading and test strips (blood glucose, ketone and urine)
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
  - Injectable glucagon’s
  - Glucagon emergency kit
  - Biohazard disposal containers
- Equipment
  - External and implantable insulin pumps and pump supplies

- Repairs and necessary maintenance of insulin pumps if not covered by manufacturer’s warranty or purchase agreement
- Rental fees for pumps during repair and maintenance
- Blood glucose monitors without special features, unless required due to blindness
- Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

**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.

### **Diagnostic lab work**

**Covered services** include:

- Lab
- Pathology
- Other tests

**Covered services** also include biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of your condition when the following requirements are met:

- Evidence-based
- Scientifically valid based on the medical and scientific evidence
- Informs a patient’s outcome and a **provider’s** clinical decision
- Predominately addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision
- Provided in a manner that will not disrupt your care or limits the number of biopsies or biospecimen samples

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

#### **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

### **Emergency services**

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

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

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.

When you are treated by an **out-of-network provider** when a **network provider** is not reasonably available or for an **emergency medical condition**, we will reimburse the **out-of-network provider** at the usual and customary rate or at an agreed rate. Please contact us if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible, coinsurance, or copayments** under your plan.

You will be credited for:

- Any amounts due to you that would have been paid if the **provider** were a **network provider**
- Any out-of-pocket amounts that you paid to the **provider**, in excess of the allowed amount. Such amounts will be credited to your Calendar Year **deductible** amount and plan **coinsurance** limits, as applicable

**Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan based on the usual and customary rate or at an agreed rate. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

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

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

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. See the *How your plan works – Medical necessity and preauthorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician (PCP)**.

### **Non-emergency services**

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

## **Hearing aids, cochlear implants and related services**

**Covered services** include hearing aids or cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to hearing aids and cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as **medically necessary** or audiologically necessary

**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
- 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
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

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

## 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 have planned medical services that are proven to result in infertility such as:
  - Surgery, chemotherapy or radiation therapy that is established in medical literature to result in infertility
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's infertility clinical policy. Aetna's infertility clinical policy is consistent with the standard procedures to preserve fertility in accordance with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine

**Covered services** also include the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue.

## 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 foods that are naturally low in protein.

**Covered services** include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid based elemental formula.

We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

The following are not **covered services**:

Any food item, including:

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

## **Orthotic devices**

**Covered services** include the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type devices that are covered by Medicare. Your **provider** will tell us which device best fits your need. But we cover it only if we **preauthorize** the device.

Orthotic device means a customized medical device applied to a part of the body to:

- Correct a deformity
- Improve function

- Relieve symptoms of a disease

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, teledentistry** 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

## 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:
  - 21<sup>st</sup> day after the date a 30-day supply is dispensed
  - 42<sup>nd</sup> day after the date a 60-day supply is dispensed
  - 63<sup>rd</sup> day after the date a 90-day supply is dispensed

## Anti-cancer drugs taken by mouth

**Covered services** include any drug prescribed for cancer treatment, including chemotherapy drugs. 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 **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. For more information see the *How your plan works – Medical necessity and preauthorization requirements* section.

## Nutritional supplements

**Covered services** include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino-acid based elemental formula.

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** are covered to the same extent that the plan covers drugs that are available only on the orders of a **physician**.

## Immunizations

**Covered services** include preventive immunizations for infectious diseases.

### Immunizations for children from birth to age 18

**Covered services include:**

- Diphtheria, tetanus, pertussis
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Inactivated poliovirus
- Influenza
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal

- Rotavirus
- Varicella
- Any other immunization that is required for children by law

**Covered services** also include immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, or a follow-up colonoscopy if the findings are abnormal
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

## Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>  No <b>deductible, copayment</b> or <b>coinsurance</b> applies to immunizations for children through age 6
Breast feeding counseling and support	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Breast feeding counseling and support limit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> services office visit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months  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 12 months  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: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
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	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (contraception counseling)	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Immunizations	100%, no <b>deductible</b> applies	50% after <b>deductible</b>  No <b>deductible, copayment</b> or <b>coinsurance</b> 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 <b>physician</b>	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 <b>physician</b>
Routine cancer screenings	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Mammogram limits	Unlimited When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.	Unlimited When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.
Prostate specific antigen (PSA) test limits	Unlimited	Unlimited
Additional routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current:  Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> or see the <i>Contact us</i> section	Subject to any age, family history and frequency guidelines as set forth in the most current:  Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> or see the <i>Contact us</i> section
Routine lung cancer screening	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Routine lung cancer screening limit	1 screenings every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Routine physical exam limits	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 adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1	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 adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1

	exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Pap smear or screening using liquid based cytology methods	One pap smear every 12 months for women age 18 or older	One pap smear every 12 months for women age 18 or older
Gynecological exam that includes a rectovaginal pelvic exam	One exam every 12 months for women over age 25 who are at risk for ovarian cancer	One exam every 12 months for women over age 25 who are at risk for ovarian cancer
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	One exam every 12 months for women age 18 and older	One exam every 12 months for women age 18 and older
Additional well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit	1 visit

## 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.

We will cover the same type devices covered by Medicare. Your **provider** will tell us which device best fits your needs.

Coverage includes:

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

If you receive a prosthetic device as part of another **covered service** 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

## Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prosthesis
- Unless you or your **physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
  - 96 hours of inpatient care following a mastectomy
  - 48 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer

## Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part, and
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.
- Your **surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if:
  - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

## Accidental injury to natural teeth

**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 accident-related dental 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

## 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
- Within scope of the services provided under an accredited rehabilitation program for brain injury.

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

## **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)

## 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.

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

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

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

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

	<b>If you are a new enrollee and your provider is out of network provider</b>	<b>When your provider stops participation with Aetna</b>
Request for approval	You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.	You or your provider should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period for up to 90 days. This date is based on the date the provider terminated their participation with us.
How claim is paid	Your claim will be paid at the designated network cost sharing level during the transitional period.	Your claim will be paid at the designated network cost sharing level during the transitional period.

	<b>If you have a terminal illness and your provider stops participation with us</b>
Request for approval	Your <b>provider</b> should call us for approval to continue any care.  You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 9 months. This date is based on the date the <b>provider</b> terminated their participation with us.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	<b>If you are pregnant and have entered your second trimester and your provider stops participation with Aetna</b>
Request for approval	Your <b>provider</b> should call us for approval to continue any care.  You can call us for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to

receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

**Important note:**

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

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**.

For certain drugs covered under your medical plan or **prescription** drug plan, 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**. We will not require more than one **preauthorization** annually for a **prescription** drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease.

## Coordination of benefits

The Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB). A plan is defined below under Key terms.

## Order of benefit determination rules

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

- |  |
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| <ul style="list-style-type: none"><li>• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan</li></ul>   |
| <ul style="list-style-type: none"><li>• A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:<ul style="list-style-type: none"><li>- Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are:<ul style="list-style-type: none"><li>○ Major medical coverages that are superimposed over base plan <b>hospital</b> and <b>surgical</b> benefits</li><li>○ Insurance type coverages that are written in connection with a closed panel to provide <b>out-of-network</b> benefits.</li></ul></li></ul></li></ul> |
| <ul style="list-style-type: none"><li>• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.</li></ul>   |

<ul style="list-style-type: none"> <li>• If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an <b>out-of-network provider</b> or <b>physician</b> except for <b>emergency services</b> or authorized <b>referrals</b> that are paid or provided by the primary plan.</li> </ul>
<ul style="list-style-type: none"> <li>• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated ad primary within the plan must be responsible for the plan’s compliance with these rules.</li> </ul>
<ul style="list-style-type: none"> <li>• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans’ benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.</li> </ul>

**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, dental, or vision 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.

<ul style="list-style-type: none"> <li>• A plan includes:</li> </ul>	<ul style="list-style-type: none"> <li>• Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage</li> <li>• Individual and group health maintenance organization evidences of coverage</li> <li>• Individual accident and health insurance policies</li> <li>• Individual and group preferred provider benefit plans and exclusive provider benefit plans</li> <li>• Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care</li> <li>• A vision benefit plan that provides coverage for vision or eye care expenses</li> <li>• Medical care components of individual and group long-term care contracts</li> <li>• Limited benefit coverage that is not issued to supplement individual or group in-force policies</li> <li>• Uninsured (i.e., self-funded or self-insured) arrangements of group or group-type coverage</li> <li>• The medical benefits coverage in automobile insurance contracts</li> <li>• Medicare or other governmental benefits</li> </ul>
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<ul style="list-style-type: none"> <li>A plan does not include:</li> </ul>	<p>as permitted by law</p> <ul style="list-style-type: none"> <li>Disability income protection coverage</li> <li>The Texas Health Insurance Pool</li> <li>Workers' compensation insurance coverage</li> <li><b>Hospital</b> confinement indemnity coverage or other fixed indemnity coverage</li> <li>Specified disease coverage</li> <li>Supplemental benefit coverage</li> <li>Specified accident coverage</li> <li>School accident-type coverages that cover students for accidents only, including athletic injuries, either on "24-hour" or a "to and from school" basis</li> <li>Benefits provided in Long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and <b>custodial care</b> or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services</li> <li>Medicare supplement policies</li> <li>A state plan under Medicaid</li> <li>A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan</li> <li>Other nongovernmental plan</li> <li>An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable <b>deductible</b></li> </ul>
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Each plan for coverage is a separate plan, If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan

**This plan:**

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans

<ul style="list-style-type: none"> <li>How this plan coordinates with like benefits:</li> </ul>	<p>Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.</p>
<ul style="list-style-type: none"> <li>The order of benefit determination rules</li> </ul>	<p>The order of benefit determination rules</p>

for this plan:	<p>determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.</p> <ul style="list-style-type: none"> <li>• When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits</li> <li>• When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense</li> </ul>
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**Allowable expense:**

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

<ul style="list-style-type: none"> <li>• Allowable expense for benefits provided in the form of services:</li> </ul>	<p>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.</p>
<ul style="list-style-type: none"> <li>• Expenses that are not allowable expenses:</li> </ul>	<p>An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a <b>provider</b> or <b>physician</b> by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.</p> <p>Some expenses and services are not allowable expenses. Here are some examples:</p> <ul style="list-style-type: none"> <li>• The difference between the cost of a semi-private <b>hospital</b> room and a private <b>hospital</b> room is not an allowable expense, unless one of the plans provides coverage for private <b>hospital</b> room expenses.</li> <li>• If a person is covered by two or more plans that don't have a <b>negotiated charge</b> 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.</li> <li>• If a person is covered by two or more plans that provide benefits or services on the basis of <b>negotiated charges</b>, an</li> </ul>

	<p>amount in excess of the highest of the <b>negotiated charges</b> is not an allowable expense.</p> <ul style="list-style-type: none"> <li>• If a person is covered by one plan that does not have <b>negotiated charges</b> 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 <b>negotiated charges</b>, the primary plan’s payment arrangement must be the allowable expense for all plans. However, if the health care <b>provider</b> or <b>physician</b> has contracted with the secondary plan to provide the benefit or service for a specific <b>negotiated charge</b> or payment amount that is different than the primary plan’s payment arrangement and if the health care <b>provider</b> or <b>physician</b> contract permits, the <b>negotiated charge</b> or payment must be the allowable expense used by the secondary plan to determine its benefits.</li> <li>• 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, <b>preauthorization</b> of admissions, and <b>network provider</b> and <b>physician</b> arrangements.</li> </ul>
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**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 the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation

## 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.

<b>COB rule</b>	<b>Primary Plan</b>	<b>Secondary plan</b>
Non-dependent or dependent	<p>Plan covering you as an employee, policyholder, retired employee or subscriber (not as a dependent)</p> <p>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</p>	<p>Plan covering you as a dependent</p> <p>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</p>
Child – parents married or living together, whether or not they have ever been married	Plan of parent whose birthday (month and day) is earlier in the calendar year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together, whether or not they have ever been married	<ul style="list-style-type: none"> <li>• Plan of parent responsible for health coverage in court order</li> <li>• Birthday rule applies if both parents are responsible or have joint custody in court order</li> <li>• Custodial parent’s plan if there is no court order</li> </ul>	<ul style="list-style-type: none"> <li>• Plan of other parent</li> <li>• Birthday rule applies (later in the year)</li> <li>• Non-custodial parent’s plan</li> </ul>
Child – covered by individuals who are not his or her parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Child of: Persons who are not his or her parents	The rules shown for parents will apply, as if the persons were parents of the child	The rules shown for parents will apply, as if the persons were parents of the child

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.
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Active or inactive employee  This rule does not apply if: <ul style="list-style-type: none"> <li>• The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits</li> <li>• The “Non-dependent or Dependent” paragraph, above can determine the order of benefits</li> </ul>	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
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Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation  This rule does not apply if: <ul style="list-style-type: none"> <li>• The other plan does not have the rule, and as a result, the plans do not agree on the order of benefits</li> <li>• The “Non-dependent or Dependent” paragraph, above can determine the order of benefits</li> </ul>	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
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Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally  This plan will not pay more than it would have paid had it been the primary plan.	Plans share expenses equally  This plan will not pay more than it would have paid had it been the primary plan.

### **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 comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

### **Facility of payment**

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### **Right of recovery**

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

### **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.

### **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 we may recover the excess from any of the following:

- Any person we paid or for whom we paid
- Any workers' compensation plan that is responsible for payment
- Any fund designed to provide benefits for workers' compensation claims

The recovery rights will be applied even if:

- The benefits are in dispute or are paid by means of settlement or compromise
- No decision has been made that the illness or injury was in the course of, or due to, your employment
- No agreement has been made by you, or the workers' compensation plan, about the amount of benefits due to health care
- The health care benefits are excluded from the workers' compensation settlement or compromise

By accepting benefits under this plan, you or your representatives agree to:

- Notify us of any workers' compensation claim made
- Reimburse us as described

### **Our rights**

We have the right to:

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

# Complaints, claim decisions and appeal procedures

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## 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 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. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determination* sections for more information

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return

If your complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

### Adverse determinations

An adverse determination is our determination that the health care services you have received, or may receive are:

- **Experimental or investigational**
- Not **medically necessary**

If we deny health care services because your **provider** does not request **preauthorization** or a concurrent claim extension, it is not an adverse determination.

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
  - A life threatening condition
  - 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	<b>Prescription drugs</b> or other intravenous infusions that you are currently receiving	Retrospective
Initial decision	No later than 1 hour after the request to the treating <b>provider</b>	Within 1 business day by phone or email to your <b>provider</b> followed by written notice within 3 business days to you and your <b>provider</b>	Within 3 business days to you and your provider	No later than 30 <sup>th</sup> day before on which the <b>prescription drugs</b> or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (us)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response to additional information request (you)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

**Important note:**

We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell no later than the times shown in the chart above.

## 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 complaint* and *Appeal of adverse determinations* sections below explain the appeal. When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

## 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.
- Aetna representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in making the decision. We will use 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 12030  
Austin, TX 78711-2030  
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 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 your member 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.

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.

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 determination. You can respond to the information before we tell you what our final decision is.

### **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.

<b>Type of claim</b>	<b>Our response time from receipt of appeal</b>
<b>Urgent care</b> 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
<b>Emergency medical condition</b>	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 <b>hospital</b> stays)	No later than 1 business day from the date all information to complete the review is received*
If you are receiving <b>prescription drugs</b> 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 <b>preauthorization</b>	As soon as possible but no later than 15 calendar days*
Requests for <b>step-therapy</b> 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** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

## Exhaustion of appeal process

In most situations, you must complete an appeal with us before you can appeal through an independent review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the 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 independent review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the Texas and the federal Department of Health and Human Services. But you will not be able to proceed directly to independent review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving **prescription drugs** or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a **step therapy** exception was denied. You can have your appeal reviewed through the independent review process.

## Independent review

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

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

- You have received an adverse determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate
- We decided the service or supply is **experimental or investigational, or unproven**

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

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

You must submit the request for independent review form:

- To Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

We will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO 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 IRO makes, unless we can show conflict of interest, bias or fraud.

### 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.

## Utilization review

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

## 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. But we will pay the fees or expenses incurred for the review of the IRO.

## Who can be a dependent on this plan

You can enroll the following family members:

- Dependent children include:
  - 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

\*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):
<ul style="list-style-type: none"> <li>• Death of employee</li> <li>• Retirement of employee</li> <li>• Retirement of employee</li> </ul>	<ul style="list-style-type: none"> <li>• Dependent who has been covered under the plan for at least one year</li> <li>• An infant under one year of age</li> </ul>	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 days 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
- The date you fail to pay premiums
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

## **Continuation of coverage for other reasons**

### **How you can extend coverage if you are totally disabled when coverage ends**

Your coverage may be extended if you are totally disabled when coverage ends. You are “totally disabled” if you cannot perform all of the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation you earned before the disability.

Your covered dependent is “totally disabled” if they can’t engage in most normal activities like a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

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

## **Administrative provisions**

### **How you and we will interpret this certificate**

We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws.

### **How we administer this plan**

We administer this plan to comply with all applicable laws and regulations. We apply policies and procedures we’ve developed to administer this plan.

### **Who’s responsible to you**

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

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

## **Coverage and services**

### **Your coverage can change**

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **preauthorization**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this. Any modifications made will be no less favorable than the current plan requirements.

## 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

You must submit written proof of loss you within 95 days after your loss occurs. If you couldn't reasonably provide this proof within 95 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 95 days ends (unless you were legally incapacitated).

## Time of payment of claims

We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above.

This does not apply to surprise bill claims.

## Records of expenses

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

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

## Honest mistakes and intentional deception

### Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years after the effective date of this certificate.

### Intentional deception

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

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

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

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an 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 your injuries. If you have a legal right to get money from a third party for causing your injuries, we are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right, you are:

- Agreeing to repay us from money you receive from those third parties because of your injury.
- Giving us the right to seek money in your name, from those third parties because of your injuries.
- Agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you'll tell us within 30 days of when you seek money from those third parties 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 our portion of the 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. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, less attorney's fees and costs for the recovery, or
- The total amount paid by us, less attorney's fees and costs for the recovery

### **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 incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan

### **Payment to a conservator, other than you**

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for **covered services** that you paid

### **Reimbursement to Texas Health and Human Services Commission**

We will repay the actual costs of medical expenses the Texas Health and Human Services Commission pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Health and Human Services Commission if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  - Have possession or access to the child through a court order; or
  - Are not entitled to possession of our access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Health and Human Services Commission.

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

### **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.

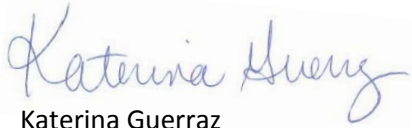
### **Telehealth**

A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

## Telemedicine

A health care service delivered by a **physician** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

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

A handwritten signature in blue ink that reads "Katerina Guerraz". The signature is written in a cursive style.

Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Texas Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Adoption benefit

**Covered services** include an adoption benefit up to \$4,000 and apply the same **copays, deductibles, and coinsurance** as any other maternity service.

Coverage is limited to the following requirements:

- The adopted child has been placed with you within 90 days from birth.
- The adopting parent(s) must submit copies of the placement papers to us.

We may seek reimbursement for the adoption benefit if:

- The post placement evaluation disapproves the adoption.
- A court rules the adoption may not be finalized.

**Important note:**

If both adopting parents have maternity coverage provided by different insurers, we will coordinate payment with the other plan and the total benefit will not exceed \$4,000. If more than one child from the same birth is adopted, only one benefit is applied.

### Applied behavior analysis

**Covered services** include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

**Diabetic supplies, drugs, and insulin important note:**

Your cost share will not exceed \$25 per 30-day supply of a covered **prescription** insulin drug. No **deductible** applies for diabetic supplies and insulin.

### Abortion

Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger, or if the fetus has a defect that is documented by a **physician** or **physicians** to be uniformly diagnosable and ultimately lethal

### **Abortion drugs**

Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger, or if the fetus has a defect that is documented by a **physician** or **physicians** to be uniformly diagnosable and ultimately lethal

### **Educational services**

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program.

## Filing a claim

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

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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision.

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

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

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

You must submit the request for external review form to:

- Utah Insurance Department
  - Mail: Utah Insurance Department Attn: Independent Review, 4315 S. 2700 W., Suite 2300, Taylorsville, UT 84129
  - Fax: 801.538.3829
- Within 180 days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Utah Insurance Commissioner 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 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.

### **Who can be a dependent on this plan**

You can enroll the following family members:

- Dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - May be covered until the last day of the month in which the child ceases to be a dependent.

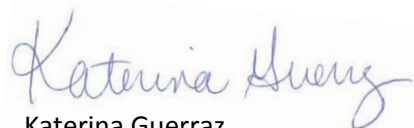
### **Recovery of overpayments**

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 provided we initiate recovery of the amount improperly paid within:

- 24 months of a coordination of benefits error
- 36 months when due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other Utah or federal health care program
- 12 months for any other reason

There is no time limit imposed on our recovery of the proceeds gained from a fraudulent insurance act.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Utah Medical ET  
Issue Date: November 17, 2025

# Aetna Life Insurance Company



## NOTICE OF PROTECTION PROVIDED BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - \$500,000 in death benefits
  - \$200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - \$500,000 for health benefit plans
  - \$500,000 in disability income insurance benefits
  - \$500,000 in long-term care insurance benefits
  - \$500,000 in other types of health insurance benefits
- Annuities
  - \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to health benefit plans.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at <https://www.ulhiga.org/>, or contact:

Utah Life and Health Insurance Guaranty Assoc.  
450 S. Simmons Way, Suite 650  
Kaysville, UT 84037  
(801) 320-9955

Utah Insurance Department  
4315 S. 2700 W., Suite 2300  
Taylorsville, UT 84129  
(801) 957-9200

## **UTAH NOTICE OF ACCESS TO HEALTH CARE PROVIDERS IN RURAL COUNTIES**

You may be entitled to coverage for health care services from noncontracted providers if you live or reside within 30 paved road miles of the providers, or if you live or reside in closer proximity to the providers than to your contracted providers.

At this time Aetna is contracted with all of the rural independent hospitals and federally qualified health centers. Please refer to your online provider directory for the most current information.

The status of contracted providers may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a noncontracted, provider you may contact your managed care organization at 1-888-646-2496 (TTY:711). If the managed care organization does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free.

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 Virginia. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

### Autism spectrum disorder

Autism spectrum disorder means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. It includes:

- Autistic disorder
- Asperger's syndrome
- Rett's syndrome
- Childhood disintegrative disorder
- Pervasive developmental disorder not otherwise specified

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

We will cover treatment ordered by a **physician** or **behavioral health provider** as part of a treatment plan they develop:

- Following a complete evaluation or re-evaluation
- In accordance with the most recent clinical report or recommendation on one of the following:
  - American Academy of Pediatrics
  - American Academy of Child and Adolescent Psychiatry.

The care within a treatment plan includes:

- Applied behavior analysis
- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care

**Medically necessary** as used here means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based on evidence and reasonably expected to do any of the following:

- Prevent the onset of an illness, condition, injury or disability;
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability; or
- Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individual of the same age.

#### **Off-label use**

FDA approved **prescription** drugs may be covered when the off-label use of the drug has not been approved by the FDA for your condition. Eligibility for coverage is subject to the following:

- The drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
- The drug is prescribed for the treatment of cancer and it is recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendium even if the drug is not approved by the FDA for a particular indication.
- The drug is approved by the FDA for use in the treatment of cancer pain and the dosage is in excess of the recommended dosage for a patient with intractable cancer pain.

#### **Insulin Important note**

Your cost share will not exceed \$50 per 30-day supply of a covered **prescription** insulin drug filled at a **network pharmacy**.

#### **Contraceptives (birth control)**

For females who are able to reproduce, **covered services** include any drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a **network pharmacy**. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

#### **Preventive contraceptives important note:**

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

#### **Referrals**

You need a **referral** from your **PCP** for most in-network **covered services**. If you do not have a **referral** when required, you will have to pay for services yourself. You do not need a **referral** for **covered services** in a **network walk-in-clinic**.

If you are a female age 13 or older, you never need a referral for well woman **covered services** from an OB/GYN **network provider** that you choose.

## Standing referral

You can ask for a standing referral from your **PCP** to a network **specialist** of your choice for certain special medical conditions. Special condition means a condition or disease that is life-threatening, degenerative, or disabling and requires special medical care over a prolonged time.

We will give you a standing **referral** if you have:

- Been diagnosed with cancer. You can choose a network **specialist** who is board-certified in pain management or oncology to provide **covered services**. The **specialist**:
  - Will consult with your **PCP**, and other **specialists** providing care, about the plan for pain management and services
  - Is not authorized to refer you to another **provider** for other **covered services**
- An ongoing special condition that your **PCP** decides, and you agree, should be managed by a network **specialist** for that condition. Within the period allowed by the standing **referral** for a special condition, the network **specialist** you choose can:
  - Treat the special condition without further **referral** from your **PCP**
  - Authorize **referrals**, procedures, tests and other **covered services** related to the special condition

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

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

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

When you have an existing **provider**-patient relationship with the **provider**, you can keep going to your current **provider**. This is called continuity of care. An existing **provider**-patient relationship means the **provider** or **provider** group has provided you with health care services or admitted or discharged you in the previous 12 months.

If this situation applies to you, contact us for details.

If the **provider** didn't leave the network for cause, you'll be able to receive transitional care from your **provider**:

- For a period of at least 90 days from when we notified you of their network status
- For a period of up to 180 days from when we notified you of their network status, if medically determined to have a life-threatening condition

### Important note:

If you have been medically confirmed to be pregnant at the time of the **provider's** termination, transitional care will be through the postpartum period.

## Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception to get coverage for drugs that are not covered or for **brand name** or **specialty drugs** or for which coverage was denied through **precertification** or **step therapy**. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Go online at <https://www.aetna.com>
- Submit the request in writing to:
  - CVS Health
  - ATTN: Aetna PA
  - 1300 E Campbell Road

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

After we receive your step therapy exception request, we will tell you and your **provider** of our coverage decision within 72 hours (including hours on weekends) or within 24 hours (including hours on weekends) if the situation is urgent.

We will grant your step therapy exception request if we determine that your request has met any of the following conditions:

- The prerequisite drug is contraindicated
- The prerequisite drug would be ineffective based on your known clinical characteristics and the drug regimen's known characteristics
- You have tried the prerequisite drug under this plan or a previous plan, and the drug was discontinued due to its ineffectiveness, reduced effect, or an adverse event
- You are currently receiving a good result on a drug recommended by your **provider** for your condition while under this plan or the plan immediately earlier

You may obtain coverage without additional cost sharing beyond that which is required of formulary **prescription** drugs for a non-formulary drug if:

- We determine, after consultation with the prescribing **provider**, that the formulary drugs are inappropriate for your condition; or
- You have been taking or using the non-formulary **prescription** drug for at least six months prior to its exclusion from the formulary; and
- The prescribing **provider** determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

We will act upon your request within one business day of receipt.

If we deny your request for a medical exception, including a step-therapy exception request, you will have the right to request an external review by an independent review organization (IRO). If our coverage decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice will also describe the external review process.

If the medical exception is approved by us or the IRO, the exception will apply for the entire time of the prescription, or in the case of an expedited exception, for the entire time you have an urgent situation. The cost share will be applied the same as for a drug listed in the drug guide.

### **Filing a claim**

This section will give you instruction on filing a claim that is not subject to surprise bill protection. All surprise bill claims will be paid in 30 days. See *Surprise bill* provision.

When you see a **provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 15 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form. Please see the *Claim forms* section for more information. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the

**medical 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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. In no event will benefits be paid later than 60 days after we receive the proof of loss. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and appeal procedures* section for that information.

### **Claim forms**

You are required to submit a claim form to us in writing. Claim forms will be furnished by us within 15 days of notification of the claim. If we fail to provide a claim form within 15 days of notification of a claim, proof of loss will be met by giving us a written statement of the nature and extent of the loss within the time limit in the *Proof of loss* section.

### **Notice of claim**

You must give us written notice of claim within 20 days after you have incurred expenses for covered services. If you don't notify us within that time and can show that it was not reasonably possible to do so, we won't void or reduce your claim. But you must send us notice as soon as reasonably possible.

### **Proof of loss**

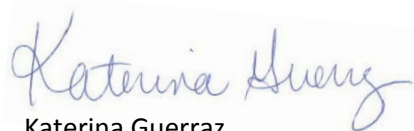
You should give us written proof of loss no later than 90 days after you have incurred expenses for covered services. We won't void or reduce your claim if it was not reasonably possible to send us proof of loss within the required time. But you must send us the proof as soon as reasonably possible. Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

### **Provider**

A **physician**, pharmacist, **health professional**, person, or facility, licensed or certified by law to provide health care services to you, including the following:

- Certified nurse midwife, nurse practitioner, or any other advanced practice registered nurse

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Virginia Medical ET

Issue Date: November 17, 2025

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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

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

### Abortion

**Covered services** include services provided and supplies used in connection with an abortion.

### Applied behavior analysis

**Covered services** include applied behavior analysis.

Applied behavior analysis is a process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

### Autism spectrum disorder

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

**Covered services** include services and supplies provided by a **health professional** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

### Clinical trials

#### Routine patient costs

**Covered services** include routine patient costs 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. An "approved clinical trial" means a

- Phase I
- Phase II
- Phase III, or
- Phase IV

clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Life-threatening disease or condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

A clinical trial must be approved or funded by one or more of the following:

- The National Institutes of Health (NIH)
- An NIH cooperative group or center (a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program)
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- The Department of Veterans Affairs
- The Department of Defense
- An Institutional review board of a Washington institution that has a multiple project contract approval by the Office of Protection for the Research Risks of the NIH

The following are not **covered services**:

- Services and supplies related to data collection and analysis needs not used in your direct clinical management
- Services and supplies provided by the trial sponsor for free
- The experimental item, device or service itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies and described below)

### **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
- Published, peer reviewed scientific evidence you may benefit from the treatment

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

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

### **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 and injection aids
  - Test strips for blood glucose, ketone and urine monitoring, including visually readable strips
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Prescribed oral medications whose primary purpose is to influence blood sugar

- Alcohol swabs
- Glucagon emergency kits
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
  - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

## Gender affirming treatment

**Covered services** include certain services and supplies for gender affirming treatment.

**Covered services** under this benefit include:

- The surgical procedure
- **Health professional** pre-operative and post-operative **hospital** and office visits
- Inpatient and outpatient services (including outpatient surgery)
- **Skilled nursing facility** care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiology services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender affirming counseling by a **behavioral health provider**
- Injectable and non-injectable hormone replacement therapy

The following are not **covered services**:

- **Cosmetic** services and supplies, unless they are **medically necessary** for treatment of gender identity disorder or gender dysphoria. Services include, but are not limited to the following:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing
  - Chin implants, nose implants, and lip reduction

### Important note:

Gender affirming treatment requires **precertification**. Your **network provider** is responsible for obtaining **precertification**. You are responsible for making sure that **precertification** is obtained if you are using an **out-of-network provider**. **Precertification** can be requested by either you or your **out-of-network provider**. Our clinical policy bulletin explains more about this care, **medical necessity** and limitations. Visit <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html> for this information. You can also call the toll-free number on your ID card.

## 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:

- You are homebound except for palliative care services

- 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
- Medical social services are provided by or supervised by a **physician**, other **health professional** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.

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

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

The following are not **covered services**:

- Funeral arrangements
- Pastoral counseling
- 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

## **Jaw joint disorder treatment**

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

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

The following are not **covered services**:

- Non-surgical and surgical dental services related to **jaw joint disorder**

## **Maternity and related newborn care**

**Covered services** include pregnancy (prenatal) care, care after delivery and obstetrical services. This includes low risk delivery in a home setting [or birthing center] as determined by the attending health professional and complications of pregnancy. 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 **health professional**, 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**. Coverage for a newborn child will be the same as the child's mother for no less than 21 days.

The following are not **covered services**:

- Any place not licensed to perform deliveries except as described above for low risk deliveries in a home setting

**Covered services** also include the inpatient use of **medically necessary** donor human milk obtained from a milk bank when prescribed by a licensed **health professional** for an infant who is medically or physically unable to receive maternal breast milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal breast milk in sufficient quantities or caloric density or participate in chest feeding. Such infant must meet at least one of the following criteria:

- Infant birth weight of less than 2,500 grams
- Infant gestational age equal to or less than 34 weeks
- Infant hypoglycemia
- A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity
- A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications
- Congenital heart disease requiring surgery in the first year of life
- An organ or bone marrow transplant

- Sepsis
- Congenital hypotonias associated with feeding difficulty or malabsorption
- Renal disease requiring dialysis in the first year of life
- Craniofacial anomalies
- An immune deficiency
- Neonatal abstinence syndrome
- Any other serious condition or acquired condition for which the use of donor human milk derived products is **medical necessary** and supports the treatment and recovery of the child
- Any infant still inpatient within 72 hours of birth without sufficient breast milk available

Donor human milk means human milk that has been contributed to a milk bank by one or more donors.

Milk bank means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

### **Neurodevelopmental therapy services**

**Covered 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

### **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 **health professional** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

**Covered services** include amino acid modified preparations, dietary specialized formulas and low protein modified food products ordered by a **health professional** for the treatment of inherited metabolic diseases including phenylketonuria or an inherited disease of amino and organic acids and eosinophilic gastrointestinal disorder.

The following are not **covered services**:

Any food item, including:

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

## Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

### Your prescription drug rights

You may contact us about your **prescription drug** benefits by calling the number on your ID card or visit [www.aetna.com](http://www.aetna.com). If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington state Office of the Insurance Commissioner at 800-562-6900 or [www.insurance.wa.gov](http://www.insurance.wa.gov). If you have a concern about the pharmacists or **pharmacies** serving you, please contact the Washington state department of health at 360-236-4700, [www.doh.wa.gov](http://www.doh.wa.gov), or [HSQACSC@doh.wa.gov](mailto:HSQACSC@doh.wa.gov).

#### Important note:

A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

**Covered services** are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section or just contact us.

You can find out if a **prescription** drug is covered; see the *Contact us* section. You may also go to <https://www.aetna.com/individuals-families/find-a-medication.html>.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

### Prescription drug synchronization

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

#### Important note:

Certain **prescription** drug cost share paid directly by you or on your behalf may count toward your **deductible** and will count toward your **maximum out-of-pocket limit**, if you have one. Contact us for details.

## Family planning services –contraceptives

**Covered services** include family planning services as follows:

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

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA

## Off-label use

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

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

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

## Mammograms

**Covered services** include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis), supplemental and diagnostic breast examinations, which may include MRI, ultrasound or mammography

## Telemedicine

**Covered services** include **telemedicine** consultations and **store and forward technology** when provided by a **physician, specialist, behavioral health provider, health professional** or other **telemedicine provider** acting within the scope of their license.

**Covered services** for **telemedicine** 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**

**provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Emails
- Faxes
- **Store and forward technology** services for which there is no related **telemedicine** consultation or office visit with the **provider**

### **Surprise bill**

There may be times when you unknowingly receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill. Review *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* that is attached to this certificate.

## Complaints, claim decisions and appeal procedures

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We previously explained how you and we share responsibility for paying for **covered services**. See the *Benefit payments and claims* section. When a claim comes in, we decide and tell you how you and we will split the expense. We also explain below what you can do if you think we got it wrong.

**Important note:** For language assistance, call us at the number on your ID card TTY:711 or visit: [www.aetna.com/individuals-families/contact-aetna/information-in-other-languages.html](http://www.aetna.com/individuals-families/contact-aetna/information-in-other-languages.html). The hearing and speech impaired may call our toll-free TDD (Telecommunications Device for the Deaf) telephone number 1-800-628-3323. To serve visually impaired enrollees, Aetna's Voice Advantage is an automated, speech recognition system that is available 24 hours a day, 7 days a week. The content of materials may be read aloud to enrollees.

### The difference between a grievance and an appeal

#### Grievance

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 or grievance. Your grievance 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 grievance. We will let you know if we need more information to make a decision.

#### Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination or adverse decision. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us verbally or in writing.

### Claim decisions and appeal procedures

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

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. There are times you may skip the internal appeal. But in most situations, you must complete the appeal process before you can pursue arbitration, litigation or other type of administrative proceeding.

## **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. We will give you an answer within 72 hours for an urgent appeal and within 14 days or 20 days for experimental or investigational treatment for a pre-service appeal. We will let you know within 72 hours that we have received your appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

### **Any other claim appeal**

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 contacting us. 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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 14 days or 20 days for experimental or investigational treatment for a post-service claim. We will let you know within 72 hours that we have received your appeal. For a pre-service or post-service claim, we may, for good cause, extend the time it takes to make a decision by up to 16 additional days if we notify you and provide a reason. If we need more time beyond the 16 additional days, we will ask for your written permission.

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 your member 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.

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 appeal process with us before you can pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the appeal process 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. See the *Contact us* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of the Washington or of the federal Department of Health and Human Services. You will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

At any time you may contact the Washington Office of the Insurance Commissioner at 800-562-6900 to request an investigation of a grievance or appeal.

## External review

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

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

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

You may also request external review if you want to know if the federal and state surprise bill and balance bill law applies to your situation. See the section *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* at the end of this Certificate.

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review form:

- To Aetna
- Within 180 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

We 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 proper expertise to do the review

- 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 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 and timely implement its determination, 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 30 calendar days after we receive your Request for 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 Expedited 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 ability to regain maximum function
  - 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 a delay in 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.

### **Utilization review**

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

### **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 in pursuing a grievance or appeal.

### **Who can be a dependent on this plan**

If your plan includes coverage for dependents, you can enroll the following family members:

- Your domestic partner who meets requirements under state law
- Dependent children – yours or your spouse’s or domestic partner’s
  - Dependent children must be:
    - Under 26 years of age

### **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 us. 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

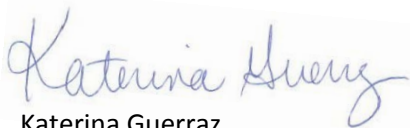
Your **premium** payment will be the same rate you were paying on the date you stopped working. But, if the **premium** amount your employer has to pay changes during the time you are extending your coverage, your **premiums** will also change.

You may elect to enroll in an individual plan by going to [wahealthplanfinder.org](http://wahealthplanfinder.org) when termination of your group coverage occurs.

### **Physician**

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

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



Katerina Guerraz  
 Executive Vice President, Chief Operating Officer  
 Aetna Life Insurance Company  
 (A Stock Company)

Amendment: Washington Medical ET  
 Issue Date: November 17, 2025



# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** PrideStaff, Inc.

**Group policy number:** GP-0805902

**Amendment effective date:** January 1, 2026

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 West Virginia. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

**Important note:**

You will not be required to pay more than \$35.00 for a thirty-day supply of a covered **prescription** insulin drug.

### 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
  - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

## 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

**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

### Mail order pharmacy

You are not required to obtain any prescription drug refill from a network mail order pharmacy or CVS pharmacy.

## 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 15 business days.

#### Post-service claim

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

#### Concurrent care claim extension

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

### **Concurrent care claim reduction or termination**

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

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **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.

### **Filing a claim**

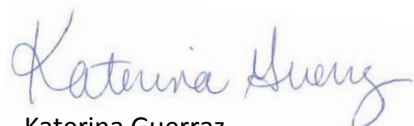
When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider**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

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 **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and appeal procedures* section for that information.

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



Katerina Guerraz  
Executive Vice President, Chief Operating Officer  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: West Virginia Medical ET  
Issue Date: November 17, 2025