

SECTION XXVI

**EXCLUSIVE PROVIDER ORGANIZATION SCHEDULE OF BENEFITS
Fashion Institute of Technology**

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| COST-SHARING | Participating Provider Member Responsibility for Cost-Sharing | |
| Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family | \$1,500 per Plan Year \$3,000 per Plan Year | |
| OFFICE VISITS | Participating Provider Member Responsibility for Cost-Sharing | Limits |
| Primary Care Office Visits (or Home Visits) | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies in Office by Telehealth | See benefit for description |
| Specialist Office Visits (or Home Visits) | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies in Office by Telehealth | See benefit for description |
| PREVENTIVE CARE | Participating Provider Member Responsibility for Cost-Sharing | Limits |
| <ul style="list-style-type: none"> • Well Child Visits and Immunizations* | Covered in full | See benefit for description |
| <ul style="list-style-type: none"> • Adult Annual Physical Examinations | Covered in full | See benefit for description |
| <ul style="list-style-type: none"> • Adult Immunizations* | Covered in full | See benefit for description |
| <ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* | Covered in full | See benefit for description |
| <ul style="list-style-type: none"> • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer | Covered in full | See benefit for description |
| <ul style="list-style-type: none"> • Sterilization Procedures for Women* | Covered in full | See benefit for description |

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| • Vasectomy | Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge) | See benefit for description |
| • Bone Density Testing* | Covered in full | See benefit for description |
| • Prostate Cancer Screening | Covered in full | See benefit for description |
| • Colon Cancer Screening* | Covered in full | See benefit for description |
| • All other preventive services required by USPSTF and HRSA | Covered in full | See benefit for description |
| *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |
| EMERGENCY CARE | Participating Provider Member Responsibility for Cost-Sharing | Limits |
| Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance) | 0% Coinsurance per trip, no Deductible applies | See benefit for description |
| Non-Emergency Ambulance Services (Ground and Air Ambulance) Preauthorization required | 0% Coinsurance per trip, no Deductible applies | See benefit for description |
| Emergency Department Copayment waived if admitted to Hospital | \$50 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing; Copayment or Coinsurance | See benefit for description |
| Urgent Care Center | \$35 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Acupuncture | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| Advanced Imaging Services • Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| • Performed in a Freestanding Radiology Facility | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| • Performed as Outpatient Hospital Services Preauthorization required | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| Allergy Testing and Treatment • Performed in a PCP; physician Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| • Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| Ambulatory Surgical Center Facility Fee Preauthorization required | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| Anesthesia Services (all settings) | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | See benefit for description |

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| Cardiac and Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Inpatient Hospital Services | Included as part of inpatient Hospital service Cost-Sharing | |
| Chemotherapy and Immunotherapy <ul style="list-style-type: none"> Performed in a PCP, physician Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed at Home | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Chemotherapy and Immunotherapy Medications | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing, Prescription Drugs) | |
| Chiropractic Services | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| Clinical Trials | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | See benefit for description |
| Diagnostic Testing <ul style="list-style-type: none"> Performed in a PCP; physician Office | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Performed in a Specialist Office | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services | 0% Coinsurance per visit, no Deductible applies | |

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| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | | See benefit for description |
| <ul style="list-style-type: none"> Performed in a PCP; physician Office | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed in a Specialist Office | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed in an Outpatient Facility | 0% Coinsurance per visit, no Deductible applies | |
| Home Health Care | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| Preauthorization required | | |
| Infertility Services | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | See benefit for description Advanced Infertility Services is limited to: 3 cycles per lifetime |
| Preauthorization required | | |
| Infusion Therapy | | See benefit for description |
| <ul style="list-style-type: none"> Performed in a PCP; physician Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed in Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services | 0% Coinsurance per visit, no Deductible applies | |
| Home Infusion Therapy | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| Preauthorization required | | |
| Inpatient Medical Visits | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| Preauthorization required | | |
| Interruption of Pregnancy | | |
| <ul style="list-style-type: none"> Abortion Services | Covered in full, not subject to Deductible | |

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| Laboratory Procedures | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Performed in a PCP Office | | |
| <ul style="list-style-type: none"> Performed in a Specialist Office | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services | 0% Coinsurance per visit, no Deductible applies | |
| Maternity and Newborn Care | | See benefit for description |
| <ul style="list-style-type: none"> Prenatal Care <ul style="list-style-type: none"> Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Covered in full | |
| <ul style="list-style-type: none"> Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early |
| <ul style="list-style-type: none"> Inpatient Hospital Services | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |
| <ul style="list-style-type: none"> Physician and Midwife Services for Delivery | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Covered for duration of breast feeding |
| <ul style="list-style-type: none"> Breastfeeding Support, Counseling and Supplies, Including Breast Pumps | Covered in full | |

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| <ul style="list-style-type: none"> • Postnatal Care <ul style="list-style-type: none"> • Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |
| <ul style="list-style-type: none"> • Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA <p>Preauthorization required for inpatient services; breast pump</p> | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |
| Outpatient Hospital Surgery Facility Charge <p>Preauthorization required</p> | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| Preadmission Testing | Use Cost-Sharing for appropriate service (Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | See benefit for description |
| Prescription Drugs Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> • Performed in a PCP, physician Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> • Performed in Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> • Performed in Outpatient Facilities <p>Preauthorization required</p> | 0% Coinsurance per visit, no Deductible applies | |

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| Diagnostic Radiology Services <ul style="list-style-type: none"> Performed in a PCP Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services Preauthorization required | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| Therapeutic Radiology Services <ul style="list-style-type: none"> Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed as Outpatient Hospital Services Preauthorization required | 0% Coinsurance per visit, no Deductible applies | |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> Performed in a PCP; physician Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | 60 visits per Plan Year combined therapies |
| <ul style="list-style-type: none"> Performed in a Specialist Office | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| <ul style="list-style-type: none"> Performed in an Outpatient Facility | 0% Coinsurance per visit, no Deductible applies | |
| Retail Health Clinic Care | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |

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| Second Opinions on the Diagnosis of Cancer, Surgery and Other | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | See benefit for description |
| Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) | | See benefit for description |
| <ul style="list-style-type: none"> Inpatient Hospital Surgery | 0% Coinsurance per admission, no Deductible applies | All transplants must be performed at designated Centers of Excellence Facilities |
| <ul style="list-style-type: none"> Outpatient Hospital Surgery | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Surgery Performed at an Ambulatory Surgical Center | 0% Coinsurance per visit, no Deductible applies | |
| <ul style="list-style-type: none"> Office Surgery <p>Preauthorization required</p> | 0% Coinsurance per visit, no Deductible applies | |
| ADDITIONAL SERVICES, EQUIPMENT and DEVICES | Participating Provider Member Responsibility for Cost-Sharing | Limits |
| Diabetic Equipment, Supplies and Self-Management Education | 0% Coinsurance per item, no Deductible applies | See benefit for description |
| <ul style="list-style-type: none"> Diabetic Equipment and Supplies | | See Prescription Drug benefit for prescription drugs |
| <ul style="list-style-type: none"> Diabetic Insulin (30-day supply) | Covered in full | |
| <ul style="list-style-type: none"> Diabetic Education | \$10 Copayment plus 0% Coinsurance per item thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | |
| Durable Medical Equipment and Braces | 0% Coinsurance per device, no Deductible applies | See benefit for description |

| INPATIENT SERVICES and FACILITIES | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Autologous Blood Banking | 0% Coinsurance per admission, no Deductible applies | See benefit for description |
| <p>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</p> <p>Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</p> | 0% Coinsurance per admission, no Deductible applies | See benefit for description |
| Observation Services | 0% Coinsurance per visit, no Deductible applies | See benefit for description |
| <p>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</p> <p>Preauthorization required.</p> | 0% Coinsurance per admission, no Deductible applies | Unlimited days per Plan Year |
| <p>Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)</p> <p>Preauthorization required</p> | 0% Coinsurance per visit, no Deductible applies | |
| <p>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</p> <p>Preauthorization required</p> | 0% Coinsurance per visit, no Deductible applies | |

| MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| <p>Inpatient Mental Health Care for a continuous confinement when in a Hospital or Residential Facility</p> <p>Preauthorization required However, Preauthorization is not required for emergency admissions or for admissions at participating Hospitals or crisis residence facilities-licensed or operated by OMH.</p> | <p>0% Coinsurance per admission, no Deductible applies</p> | <p>See benefit for description</p> |
| <p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> • Office Visits | <p>\$10 Copayment plus 0% per Coinsurance visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies</p> <p>in Office</p> <p>by Telehealth</p> | <p>See benefit for description</p> |
| <ul style="list-style-type: none"> • All Other Outpatient Services <ul style="list-style-type: none"> • Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH | <p>0% Coinsurance per visit, no Deductible applies</p> | |
| <ul style="list-style-type: none"> • All Other Outpatient Services <p>Preauthorization required. However, Preauthorization is not required for participating crisis stabilization centers licensed by OMH.</p> | <p>0% Coinsurance per visit, no Deductible applies</p> | |

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| <p>ABA Treatment for Autism Spectrum Disorder</p> <p>Preauthorization required</p> | <p>0% Coinsurance per visit, no Deductible applies</p> | <p>See benefit for description</p> |
| <p>Assistive Communication Devices for Autism Spectrum Disorder</p> <p>Preauthorization required</p> | <p>0% Coinsurance per device, no Deductible applies</p> | <p>See benefit for description</p> |
| <p>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization required. However, Preauthorization is not required for emergency admissions or for participating Facilities licensed, certified or otherwise authorized by OASAS.</p> | <p>0% Coinsurance per admission, no Deductible applies</p> | |
| <p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> • Office Visits | <p>\$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies</p> <p>in Office</p> <p>by Telehealth</p> | |
| <ul style="list-style-type: none"> • All Other Outpatient Services <ul style="list-style-type: none"> • Opioid Treatment Programs | <p>0% Coinsurance per visit, no Deductible applies</p> | |
| <ul style="list-style-type: none"> • All Other Outpatient Services <p>Preauthorization required. However, Preauthorization is not required for participating Facilities licensed, certified or otherwise authorized by OASAS.</p> | <p>0% Coinsurance per visit, no Deductible applies</p> | |

| PRESCRIPTION DRUGS *Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Retail Pharmacy | | |
| 30-day supply Tier 1 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. | \$5 Copayment per supply, no Deductible applies | See benefit for description |
| Tier 2 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. | \$15 Copayment per supply, no Deductible applies | See benefit for description |
| Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. | \$30 Copayment per supply, no Deductible applies | See benefit for description |

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| Mail Order Pharmacy | | | |
| Up to a 90-day supply Tier 1 | \$10 Copayment per supply, no Deductible applies | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Tier 2 | \$30 Copayment per supply, no Deductible applies | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Tier 3 | \$60 Copayment per supply, no Deductible applies | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Enteral Formulas | Coinsurance is 0% per supply, no Deductible applies | | See benefit for description |

| VISION CARE | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Pediatric Vision Care • Exams | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | One (1) exam per 12-month period |
| Adult Vision Care • Exams | \$10 Copayment plus 0% Coinsurance per visit thereafter and will not exceed 50% of the Allowed Amount, no Deductible applies | One (1); exam per 24-month period |

Aetna Life Insurance Company

Aetna Concierge Program Rider

Policyholder: Fashion Institute of Technology

Group policy number: GP-0100160

Rider effective date: January 1, 2026

Your health plan has changed. The Certificate is revised to reflect this. This change is effective on the date shown above.

The *Aetna Concierge Program* has been added to Your health plan as follows:

Aetna Concierge Program

Your plan of benefits includes the Aetna Concierge program.

The program provides immediate access to healthcare resource consultants who have been specifically trained in the details of Your medical and pharmacy benefits plans.

You may phone, email or in some situations text Your Aetna Concierge team instead of contacting Aetna member services. The Concierge will help You to identify the right Aetna tools, resources and benefit programs available under the plan based on Your individual health care needs.

Concierge services include, but are not limited to:

- Detailed plan and benefit information integrated across all available resources – both Aetna and non-Aetna, designed to simplify and maximize Your member experience. The Concierge service will help reduce the time You spend searching for this information on Your own;
- One-on-one information and instruction, either by telephone, email, on Aetna's online member tools, including:
 - Aetna's online member services system; and
 - the Aetna online network provider directory;
- Help with billing and or claims issues related to Your plans;
- Timely health care alerts that include information on the Aetna programs that may be beneficial for Your specific health care needs;
- What Aetna describes as a *360° View* of the network providers, care management programs, Aetna-affiliated vendors and even external vendor resources that may work well for You alongside Your plan;
- Personalized reports matching You to these providers, programs and vendors.

Once You and Your Aetna Concierge have identified appropriate resources, the Concierge

can transfer You directly to this provider, program representative or vendor, and will stay on the line with You until the transfer is complete.

How to Contact An Aetna Concierge

To contact an Aetna Concierge for questions on Your medical and pharmacy, Coverage.

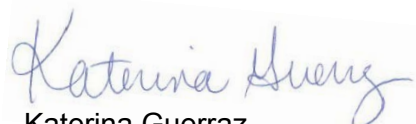
You can log onto to www.aetna.com or call the toll-free number on the back of Your ID Card from 8 a.m. to 6 p.m. Monday through Friday to reach an Aetna Concierge.

Only participants enrolled in Your plans have access to this toll-free Aetna Concierge telephone number. Individuals contacted via this number are specifically trained to answer questions about Your plans. In addition to offering expanded and personalized information about Your plan, the Concierge is also able to transfer You directly to both internal and external contacts related to Your plan. Your Aetna Concierge will remain on the line with You until the transfer is completed.

Individuals contacted via the Aetna Concierge telephone number are specifically trained to answer questions about Your plan. In addition to offering expanded and personalized information about Your plan, the Concierge is also able to transfer You directly to both internal and external contacts related to Your plan.

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.



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

Aetna Concierge Program
Rider 002
Issue Date: October 24, 2025

Aetna Life Insurance Company

Aetna's National Infertility Unit Rider

Policyholder: Fashion Institute of Technology

Group policy number: GP-0100160

Rider effective date: January 1, 2026

Your health plan has changed. The Certificate is revised to reflect this. This change is effective on the date shown above.

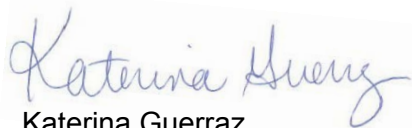
Aetna's National Infertility Unit has been added to the *Outpatient and Professional Services* section under *Infertility Treatment – Comprehensive Infertility Services* provision of Your health plan as follows:

Aetna's National Infertility Unit

The first step to using Your Comprehensive Infertility Services is enrolling with Our National Infertility Unit (NIU). Our NIU is here to help You. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help You with determining eligibility for benefits. They can also help Your Provider with Preauthorization. You can call the NIU at 1-800-575-5999.

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.



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

National Infertility Unit
Rider 007
Issue Date: October 24, 2025

Aetna Life Insurance Company

Oral Surgery Rider

Policyholder: Fashion Institute of Technology

Group policy number: GP-0100160

Rider effective date: January 1, 2026

Your health plan has changed. The Certificate of Coverage is revised to reflect this. This change is effective on the date shown above.

The *Oral Surgery* provision has been added to the *Outpatient and Professional Services* section of Your Certificate as follows:

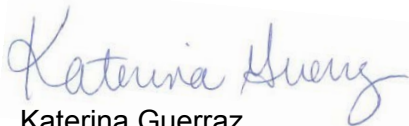
Oral Surgery

We cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental Injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the Injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.
- Oral surgical procedures to cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth.

All other terms and conditions of the policy, Certificate and Schedule of Benefits apply.

This rider makes no other changes to the policy, Certificate or Schedule of Benefits.



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

Oral Surgery
Rider 008
Issue Date: October 24, 2025

Aetna Life Insurance Company

No Surprises Act Rider

This rider amends the sections listed below of Your Certificate to provide the consumer protections required under the Federal No Surprises Act.

1. Paragraph C from How Your Coverage Works section is replaced with the following:

C. Participating Providers.

To find out if a Provider is a Preferred or Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website www.aetna.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Provider is a Preferred Provider; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any Copayment, Deductible or Coinsurance that would apply to the Covered Services, and You are not responsible for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one business day of Your telephone request for network status information.

2. Paragraph N from How Your Coverage Works section is replaced with the following:

N. Protection from Surprise Bills.

1. Surprise Bills. A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
 - A participating Provider is unavailable at the time the health care services are performed;
 - A non-participating Provider performs services without Your knowledge; or
 - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Provider is available and You elected to receive services from a non-participating Provider.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
 - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
 - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
 - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. You can sign a form to let Us and the Non-Participating Provider know You received a surprise bill.

The form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.aetna.com for a copy of the form. You need to mail a copy of the form to Us at the address on Our website and to Your Provider.

2. 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. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

3. Paragraph E from the Access to Care section is replaced with the following:

E. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, Referrals; authorizations, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Copayment, Deductible or Coinsurance. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

4. A new paragraph is added to the Ambulance and Pre-Hospital Emergency Medical Services as follows:

Payments for Air Ambulance Services. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance 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 air ambulance services is submitted to an independent dispute resolution entity, We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us. Visit Our website at www.aetna.com or www.dfs.ny.gov for more information on the independent dispute resolution process for air ambulance bills.

5. Item 3 under Paragraph A titled “Emergency Services” in the Emergency Services and Urgent Care section is replaced with the following:

3. Payments Relating to 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 Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us.

6. Controlling Certificate.

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.



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

No Surprises Act
Rider 016
Issue Date: October 24, 2025

Aetna Life Insurance Company

Section XIII

Network Access for Mental Health Care and Substance Use Services Rider for Large Group Comprehensive Health Insurance Certificate for 2025

Rider effective date: January 1, 2026

I. General.

This rider adds the following subsection to the Mental Health Care and Substance Use Services section of Your Certificate.

C. Network Access for Mental Health Care and Substance Use Services.

1. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

- **Access Complaint:** Your complaint to Us when You cannot access a Participating Provider within the required Appointment Wait Time.
- **Appointment Wait Time:** The time from the initial request for outpatient mental health care or outpatient substance use services to the earliest date offered for the appointment for services.

2. Network Provider Access

When You request an appointment for outpatient mental health care or outpatient substance use services, a Participating Provider must offer You an appointment within the following Appointment Wait Times:

- Ten (10) business days for an initial appointment; and
- Seven (7) calendar days for an appointment following a discharge from a Hospital or an emergency room visit.

The above timeframes can be satisfied through a telehealth visit with a Participating Provider, unless You specifically request an in-person visit.

We have designated staff to assist You in finding a Participating Provider who can treat Your mental health condition or substance use disorder. You may contact Our designated staff by calling 800-424-4027.

If there is not a Participating Provider available within the Appointment Wait Time who can treat Your mental health condition or substance use disorder, You or Your designee may submit an Access Complaint to Us by:

- Calling 800-424-4047,
- Writing to us at
Aetna Customer Resolution Team
P.O. Box 14462
Lexington, KY 40512
- Electronically by visiting Our website <https://www.aetna.com>.

Upon receipt of Your Access Complaint, We have three (3) business days to locate a Participating Provider who can (1) treat Your mental health condition or substance use disorder, (2) is able to meet the Appointment Wait Time, and (3) is located within a reasonable distance from You if You request an in-person appointment (rather than a telehealth appointment). If We cannot locate a Participating Provider who meets these requirements, We will:

- Notify You by telephone, if Your request was made by telephone, and in writing, that You may obtain a Referral or authorization to a Non-Participating Provider at the In-Network Cost-Sharing; and
- Approve a Referral or authorization to a Non-Participating Provider who:
 - Can treat Your mental health condition or substance use disorder;
 - Is able to meet the Appointment Wait Time;
 - Is located within a reasonable distance from You if You request an in-person appointment; and
 - Charges rates that are not excessive or unreasonable.

The Referral or authorization will remain in effect until the earlier of the following:

- The services are no longer Medically Necessary; or
- We locate a Participating Provider who:
 - Can treat Your mental health condition or substance use disorder;
 - Is able to meet the Appointment Wait Time;
 - Is located within a reasonable distance from You if You request an in-person appointment; and
 - Your treatment can be transitioned to the Participating Provider, unless We determine, in consultation with Your treating Provider, as appropriate, that such transition would be harmful to You.

Covered Services rendered by the Non-Participating Provider will be Covered by Us as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. Any Cost-Sharing that would have applied had the services been received from a Participating Provider will apply toward Your In-Network Out-of-Pocket Limit.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external Appeal of Our determination that a service is not Medically Necessary and the Grievance section of this Certificate for any other determination.

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)

Rider: 024

Issue Date: October 24, 2025

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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



IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.



Important disclosure information about New York group and Student Health plans

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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Here is important disclosure information about our plans. It's followed by required content that varies by state.

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit <https://www.aetna.com/content/dam/aetna/pdfs/aetna.com/individuals-families-health-insurance/document-library/documents/plan-disclosures/NCQA-MED-Dsclsr-FI-SI.pdf> to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

Know the costs and rules for using your plan

- What you'll pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a group plan

If you're a member, not all of the information in this document applies to your specific plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

How some plans pay

Providers set the rates to charge you. It may be higher (sometimes, much higher) than what your Aetna® plan allows. For some plans, your doctor may bill you for the dollar amount that the plan doesn't allow and no dollar amount above the allowed charge will count toward your deductible or out-of-pocket limits. This means you're fully responsible for paying everything above the amount the plan allows for a service or procedure. However, emergency care is always covered by your plan, and you don't have to get prior approval. Plans pay for your health care depending on the plan that you, or your employer, chooses. Some plans pay for services by looking at what Medicare would pay and adjusting that amount up or down. Plans range from paying 90% of Medicare (that is 10% less than Medicare would pay) up to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for services based on what is called the "usual and customary" charge. These plans use information from FAIR Health, Inc., a not-for-profit company that reports how much providers charge for services in any ZIP code. You can call Member Services at the number on your member ID card to find out the method your plan uses to pay providers.

Not yet a member?

For help understanding how a certain medical plan works, review the plan's Summary of Benefits and Coverage document.

Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our national network

Visit [Aetna.com](https://www.aetna.com) to find providers who are part of your plan's network. There you can learn more about network care and how we pay out-of-network benefits when a plan allows them.

Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your member ID card. If you're not yet a member, call [1-888-982-3862](tel:1-888-982-3862) (TTY: [711](tel:711)).

No coverage, based on financial sanctions

Complying with financial sanctions laws and regulations is a top priority. If applicable sanctions, laws and regulations, such as those under the Department of Treasury's Office of Foreign Assets Control ("OFAC"), consider you a "designated person," the plan cannot provide benefits or coverage to you. Likewise, traveling to a U.S. sanctioned location (e.g. Cuba) for medical treatment in most cases, will prohibit benefits or coverage. These regulations also apply if your health care provider is a designated person or is located in a sanctioned location. For more information, visit [Treasury.gov/resource-center/sanctions/pages/default.aspx](https://www.treasury.gov/resource-center/sanctions/pages/default.aspx).

Coverage for transplants

Our National Medical Excellence Program® (NME) is for members who need a transplant. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents. CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can visit [Aetna.com/health-care-professionals/clinical-policy-bulletins.html](https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html) to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

Member rights and responsibilities

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care and to serve you better.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents.

Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.

- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan. If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

Please contact Member Services for more information. Or follow these links to learn more.

Fact sheet from the U.S. Department of Health and Human Services: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

Pamphlet from the U.S. Department of Labor: <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf>

Your right to enroll later

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

Important information for New York plans

Using your NY plan

You may have more time to enroll

If you've lost your Medicaid insurance, you may have more time to enroll in an Aetna plan.

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

A PCP may be a general practitioner, family physician, internist or a pediatrician. Each covered family member may select his or her own PCP. Your PCP provides routine preventive care and will treat you for illness or injury. Your PCP may refer you to other network doctors and hospitals for covered services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization.

The online provider directory indicates whether a provider is accepting new patients. You can also ask the provider's office to confirm when scheduling an appointment.

Tell us who you chose to be your PCP

Each member of the family may choose a different PCP from the Aetna network. Enter the ID number of the PCP you choose on your enrollment form.

You can change your PCP or specialist at any time. Log in at [Aetna.com](https://www.aetna.com) or call the Member Services toll-free number on your Aetna ID card. The change will become effective when we receive and approve the request.

Making your specialist your PCP

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with

expertise in treating the life-threatening or degenerative and disabling disease or condition, who will be responsible for

and capable of providing and coordinating your primary and specialty care. This referral will be issued based on a

treatment plan that is approved by Aetna, in consultation with the primary care provider if appropriate, the specialist,

and you or your authorized representative. Please call Member Services at the toll-free number in your ID card

or call [1-888-982-3862](tel:1-888-982-3862) (TTY: [711](tel:711)) to request these services.

Colorectal Cancer Screenings

Your plan covers colorectal cancer screenings in accordance with the standards set forth by the American Cancer Society and the American Gastroenterological Association. For more information:

Visit the American Cancer Society at:

<https://standuptocancer.org/news/american-cancer-society-updates-colorectal-cancer-screening-guideline/?gclid=EAlalQobChMIncf7ju-V QIV B8zlCh06pgmiEAAYASAAEgLn1fD BwE>

Visit the American Gastroenterological Association at:

<https://gastro.org/clinical-guidance/reducing-the-burden-of-colorectal-cancer-crc/>

Direct Access Ob/Gyn program

This program allows female members direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such examinations, and treatment of acute gynecologic conditions, including care for pregnancy-related services, from a qualified participating provider of the member's choice.

Direct specialist care for life threatening conditions

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center or to a specialist responsible for providing or coordinating your medical care. To request these services, please call Member Services at the toll-free number on your ID card or call [1-888-982-3862](tel:1-888-982-3862) (TTY: [711](tel:711)).

Not all plans require referrals: Your PCP will refer you to a specialist when needed

You never need to get a referral if you have an Aetna Open Access® Managed Choice, Aetna Open Access®

Elect Choice or Open Choice® plan. With the Managed Choice plan, you will receive the highest level of benefits under the plan when you get a referral from your PCP before you see a network specialist.

A referral is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved. Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Getting a referral from your PCP is not the same as getting approval (called precertification) from the plan. Some health care services require both. For more information, read the "Precertification: getting approvals for services" section of this booklet.

Remember these points about referrals:

- You do not need a referral for emergency care or urgent care.
- If you do not get a referral when required, the plan will pay for the service as an out-of-network benefit, if available.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "Direct Access Ob/Gyn program."
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. See the "Precertification: getting approvals for services" section for details.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

Out-of-network referrals

If a covered service you need isn't available from a network provider or facility with the training or expertise needed for your condition, or if a participating provider is not geographically accessible, your PCP may refer you to an out-of-network provider. Your PCP or other network provider must get preapproval from Aetna and issue a special nonparticipating referral for services from out-of-network providers to be covered.

Standing referrals

If you have a condition that requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist.

You don't need a PCP referral for:

- Emergency care — see the "Emergency care" section to learn more
- Urgent care — see the "Emergency care" section to learn more
- Direct access services — certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the "What the Plan Covers" and the "Summary of Benefits" sections of your plan documents. You can directly access these network specialists for:
 - Routine gynecologist visits
 - Routine eye exams in accordance with the schedule
 - An annual screening mammogram for age-eligible women
 - Routine prenatal care (precertification may be required)

Precertification: getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that precertification or preauthorization. We usually only need to precertify more serious care like surgery or being admitted to a hospital. Your PCP or Aetna network doctor will get this approval for you. If the request is to go outside the network, you may have to get this approval yourself. To do so, call the precertification number on your Aetna ID card, [1-877-204-9186](tel:1-877-204-9186) (TTY: [711](tel:711)), or send your request to:

Aetna
1425 Union Meeting Road
Blue Bell, PA 19422

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

Member Cost of Care tool for New York members

If a service or procedure is not listed in the member Cost of Care tool on your member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate form on our website. Please visit the state information section at [Aetna.com https://www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html](https://www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html) for the form or to link to an online price estimator tool. An "out of network" doctor is one with whom we do not have a contract for discounted rates. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to see an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes, or allows. Your doctor may bill you for the dollar amount the plan doesn't recognize. You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90% of Medicare (that is, 10% less than Medicare would pay) to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the usual and customary charge or reasonable amount rate. These plans use information from FAIR Health, Inc. (Fairhealth.org), which is a not-for-profit company that reports how much providers charge for services in any ZIP code.

When you choose to enroll in a plan with out-of-network coverage, you should consider how plans based on Medicare rates compare to plans based on "usual and customary" charges. Roughly speaking, in New York for all services combined, 325-350% of Medicare rates are the same as the usual and customary charges.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you choose to get care out of network.

Emergency care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world.

Emergency condition

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

- 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

Treatment for an emergency medical condition is not subject to prior approval. However, whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.

If you are admitted to an inpatient facility, you or a family member or friend acting on your behalf should notify your PCP or Aetna as soon as possible.

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

Urgent care

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

Claims for emergency care

We'll review the information when the claim comes in. If we think the situation was not an emergency, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone. Emergency care expenses that are not related to an emergency medical condition are excluded and are your financial responsibility.

Follow-up care for plans that require a PCP

Your PCP should coordinate any follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating urgent care facilities.

We check if it's medically necessary

We cover benefits described in your certificate as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, "service") is medically necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it medically necessary or mean that we have to cover it.

We may base our decision on a review of:

- Your medical records
- Our medical policies and clinical guidelines
- Medical opinions of a professional society, peer review committee or other groups of physicians
- Reports in peer-reviewed medical literature
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment

- The opinion of health care professionals in the generally recognized health specialty involved
 - The opinion of the attending providers, which have credence but do not overrule contrary opinions
- Services will be deemed medically necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and are considered effective for your illness, injury, or disease
 - They are required for the direct care and treatment or management of that condition
 - Your condition would be adversely affected if the services were not provided
 - They are provided in accordance with generally accepted standards of medical practice
 - They are not primarily for the convenience of you, your family, or your provider
 - They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be medically necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a physician's office or the home setting.

See the Utilization Review and External Appeal sections of this document or in your certificate of coverage for your right to an internal appeal and external appeal of our determination that a service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do. If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit [Aetna.com](https://www.aetna.com) to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies.

To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective any treatments and technologies are.
- See what other medical and government groups say about treatments and technologies. That includes the federal Agency for Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully treatments and technologies have been used.

We publish our decisions in our Clinical Policy Bulletins.

How to file a claim

For most services, network doctors will file your claims for you. If you go outside the network, you may need to file claims yourself. Your health care professional may file a claim within 120 days from the date of service. You may also file a claim yourself.

We accept claims by mail, fax and electronically. If you need to file a claim with us, please call Member Services at the number on your Aetna ID card. The representative will give you the mailing address, email address or fax number for our claims office. You can also log in to your member website at [Aetna.com](https://www.aetna.com) to download a claim form (which includes the mailing address) or to send the claim electronically. To send the claim electronically, log in to [Aetna.com](https://www.aetna.com) and click "Contact" in upper right corner.

You can submit a claim form as an attachment.

Our plans comply with mental health laws

We want you to know that our plans comply with all federal and NY state requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes the non-quantitative treatment limitation (NQTL) requirements applied to behavioral health and substance use disorder benefits. We use the same processes and standards to determine these requirements as those we use to determine requirements for medical and surgical treatments. In other words, we apply the same medical management requirements, such as precertification, to all plan benefits, including:

- Behavioral health
- Substance use disorder
- Medical and surgical treatments

If you'd like to see how we arrive at the NQTL requirements, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

How we determine cost share

To ensure that we comply with federal and state mental health laws regarding members' cost share, we apply certain test measures laid out in the federal law. These are called the "substantially all" and "predominant level" tests. If you'd like to see how we arrive at members' cost share, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

What to do if you disagree with us

A. Grievances

Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

B Filing a grievance

You can contact us by phone at the number on your ID card, in person, or in writing to file a grievance. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

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

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

You may ask that we send you electronic notification of a grievance or grievance appeal determination instead of notice in writing or by telephone. You must tell us in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit our website Aetna.com. You can opt out of electronic notifications at any time.

C. Grievance determination

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following time frames.

Time frames for determining a grievance

| Type of grievance | Level 1 appeals |
|---|---|
| Expedited/urgent grievance | By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance. |
| Preservice grievance (a request for a service or treatment that has not yet been provided) | In writing, within 15 calendar days of receipt of your grievance |
| Postservice grievance (a claim for a service or a treatment that has already been provided) | In writing, within 30 calendar days of receipt of your grievance |
| All other grievances (those that are not in relation to a claim or request for service) | In writing within 30 calendar days of receipt of your grievance |

Grievance appeals

(Does not apply to Student Health plans.) If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone, in person or in writing. You may file an urgent appeal by phone. You have up to 60 business days from receipt of our decision to file an appeal.

When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your appeal. If necessary, it will also inform you of any additional information we may need to make a decision. One or more qualified personnel at a higher level than the person who rendered the complaint decision will review the appeal. If it is a clinical matter, a clinical peer reviewer will look into it.

Time frames for determining your appeal of a grievance determination:

(Does not apply to Student Health plans.)

| Type of grievance | Level 1 appeals |
|---|---|
| Expedited/urgent grievance | By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance. |
| Preservice grievance (a request for a service or treatment that has not yet been provided) | In writing, within 15 calendar days of receipt of your grievance |
| Postservice grievance (a claim for a service or a treatment that has already been provided) | 30 calendar days of receipt of your appeal |
| All other grievances (those that are not in relation to a claim or request for service) | In writing within 30 calendar days of receipt of your grievance |

If you are not satisfied or if you need help

If you remain dissatisfied with our appeal determination, or at any other time you are dissatisfied, you may:

- Call the New York State Department of Financial Services at [1-800-342-3736](tel:1-800-342-3736)
- Write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
- Visit their website: www.dfs.ny.gov

If you need assistance filing a grievance, you may also contact the state independent Consumer Assistance Program:

- Write them at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
- Call toll free: [1-888-614-5400](tel:1-888-614-5400)
- Email: cha@cssny.org
- Visit their website:
www.communityhealthadvocates.org

Appointing a designee

You have the right to appoint a designee to handle your grievance, appeal or utilization review request.

A. Utilization review

We review health services to determine whether the services are or were medically necessary or experimental or investigational (“medically necessary”). This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the service being performed (preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process for services including mental health and substance use services, please call the number on your ID card. The toll- free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not medically necessary will be made by:

- Licensed physicians or
- Licensed, certified, registered or credentialed; health care professionals who are in the same profession and same or similar specialty as the provider who typically manages your medical condition or disease or provides the health care service under review or
- With respect to mental health or substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not medically necessary. We have developed guidelines and protocols to assist us in this process. We will use evidence-based and peer-reviewed clinical review criteria that are appropriate to the age of the patient and designated by Office of Addiction Services and Supports (OASAS) for substance use disorder treatment or approved for use by Office of Mental Health (OMH) for mental health treatment. Specific guidelines and protocols are available for your review upon request. For more information, call the number on your ID card or visit our website at [Aetna.com](https://www.aetna.com).

You may ask that we send you electronic notification of a utilization review determination instead of notice in writing or by telephone. You must tell us in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit our website [Aetna.com](https://www.aetna.com). You can opt out of electronic notifications at any time.

B. Preauthorization reviews

- (1) **Non-urgent preauthorization reviews.** If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of receipt of the request.

If we need additional information, we will request it within three (3) business days. You or your provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

- (2) **Urgent preauthorization reviews.** With respect to urgent preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period.
- (3) **Court-ordered treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, we will make a determination and provide notice to you (or your designee) or your provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

- (4) **Inpatient rehabilitation services reviews.** After receiving a preauthorization request for coverage of inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.
- (5) **Crisis stabilization centers.** Effective January 1, 2022, coverage for participating crisis stabilization centers licensed under Mental Hygiene Law section 36.1 is not subject to preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is medically necessary, and we will use clinical review tools designated by OASAS or approved by OMH. If any treatment is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your treatment.
- (6) **Site of service reviews.** Our precertification program is aimed at minimizing members' out-of-pocket costs and improving overall cost efficiencies. It requires that the more cost-effective site of service is used for certain outpatient surgical procedures, when clinically appropriate. Elective surgical procedures identified in this program should be performed in an ambulatory surgical center (ASC) or office setting unless the medical necessity criteria is met. For additional site of service criteria, please visit our website <https://www.aetna.com/health-care-professionals/outpatient-surgical-procedures.html>.

C. Concurrent reviews

- (1) **Non-urgent concurrent reviews.** Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) or your provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) or your provider, by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.
- (2) **Urgent concurrent reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you (or your designee) or your provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and we have all the information necessary to make a determination, we will make a determination and provide written notice to you (or your designee) or your provider within the earlier of 72 hours or one (1) business day of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide written notice to you (or your designee) or your provider within the earlier of one (1) business day or 48 hours of our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

- (3) **Home health care reviews.** After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) or your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) or your provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.
- (4) **Inpatient substance use disorder treatment reviews.** If a request for inpatient substance use disorder treatment is submitted to us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, we will make a determination within 24 hours of receipt of the request and we will provide coverage for the inpatient substance use disorder treatment while our determination is pending.
- (5) **Inpatient mental health treatment for members under 18 at participating hospitals licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed hospital is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed hospital notifies us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, we may review the entire stay to determine whether it is medically necessary, and we will use clinical review tools approved by OMH. If any portion of the stay is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your inpatient admission.
- (6) **Inpatient substance use disorder treatment at participating OASAS-certified facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified facility notifies us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, we may review the entire stay to determine whether it is medically necessary, and we will use clinical review tools designated by OASAS. If any portion of the stay is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your inpatient admission.
- (7) **Outpatient substance use disorder treatment at participating OASAS-certified facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified facility notifies us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, we may review the entire outpatient treatment to determine whether it is medically necessary, and we will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your outpatient treatment.

D. Retrospective reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of our receipt of all or part of the requested information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

E. Retrospective review of preauthorized services

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

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

F. Step therapy override determinations

You, your designee, or your health care professional may request a step therapy protocol override determination for coverage of a prescription drug selected by your health care professional. When conducting utilization review for a step therapy protocol override determination, we will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

- (1) **Supporting rationale and documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a health care professional, demonstrating that:
 - The required prescription drug(s) is contra indicated or will likely cause an adverse reaction or physical or mental harm to you;
 - The required prescription drug(s) is expected to be ineffective based on your known clinical history, condition, and prescription drug regimen;
 - You have tried the required prescription drug(s) while covered by us or under your previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
 - You are stable on a prescription drug(s) selected by your health care professional for your medical condition, provided this does not prevent us from requiring you to try an AB-rated generic equivalent; or
 - The required prescription drug(s) is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a co-morbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

(2) **Standard review.** We will make a step therapy protocol override determination and provide notification to you (or your designee) and where appropriate, your health care professional, within 72 hours of receipt of the supporting rationale and documentation.

(3) **Expedited review.** If you have a medical condition that places your health in serious jeopardy without the prescription drug prescribed by your health care professional, we will make a step therapy protocol override determination and provide notification to you (or your designee) and your health care professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, we will request the information within 72 hours for preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or your health care professional will have 45 calendar days to submit the information for preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews.

For preauthorization reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours or one (1) business day of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 24 hours of our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If we do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved. If we determine that the step therapy protocol should be overridden, we will authorize immediate coverage for the prescription drug prescribed by your treating health care professional. An adverse step therapy override determination is eligible for an appeal.

G. Reconsideration

If we did not attempt to consult with your provider who recommended the covered service before making an adverse determination, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your provider, by telephone and in writing.

H. Utilization review internal appeals

You, your designee, and, in retrospective review cases, your provider, may request an internal appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. The appeal will be decided by a clinical peer reviewer who is not a subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a physician or 2) a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue.

(1) **Out-of-network service denial.** You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a non-participating provider, but only when the service is not available from a participating provider. For a utilization review appeal of denial of an out-of-network health service, you or your designee must submit:

- A written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a participating provider that we approved to treat your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

(2) **Out-of-network referral denial.** You also have the right to appeal the denial of a request for a referral to a non-participating provider when we determine that we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a utilization review appeal of an out-of-network referral denial, you or your designee must submit a written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition:

- That the participating provider recommended by us does not have the appropriate training and experience to meet your particular health care needs for the health care service; and
- Recommending a non-participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

I. First-level appeal

- (1) **Preauthorization appeal.** If your appeal relates to a preauthorization request, we will decide the appeal within 15 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the appeal request.
- (2) **Retrospective appeal.** If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

- (3) **Expedited appeal.** An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal. Written notice of the determination will be provided to you (or your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your appeal within 30 calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

(4) **Substance-use appeal.** If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal appeal of our adverse determination, we will decide the appeal within 24 hours of receipt of the appeal request. If you or your provider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of our adverse determination, we will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

J. Full and fair review of an appeal

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

K. Second-level appeal

(Does not apply to Student Health plans.) If you disagree with the first-level appeal determination, you or your designee can file a second-level appeal. You or your designee can also file an external appeal. The four-month time frame for filing an external appeal begins on receipt of the final adverse determination on the first level of appeal. By choosing to file a second-level appeal, the time may expire for you to file an external appeal.

A second-level appeal must be filed within 45 days of receipt of the final adverse determination on the first-level appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will inform you, if necessary, of any additional information needed before a decision can be made.

(1) **Preauthorization appeal.** If your appeal relates to a preauthorization request, we will decide the appeal within 15 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the appeal request.

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

(3) **Expedited appeal.** If your appeal relates to an urgent matter, we will decide the appeal and provide written notice of the determination to you (or your designee), and where appropriate, your provider, within 72 hours of receipt of the appeal request.

L. Appeal assistance

If you need assistance filing an appeal, you may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

Or call toll free: [1-888-614-5400](tel:1-888-614-5400), or Email cha@cssny.org

Website: www.communityhealthadvocates.org

External appeal

A. Your right to an external appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal, you must meet the following two (2) requirements:

- The service, procedure or treatment must otherwise be a Covered Service under this Certificate; and
- In general, you must have received a final adverse determination through the first level of Our internal Appeal process. But, you can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your right to appeal a determination that a service is not medically necessary

If We have denied coverage on the basis that the service is not Medically Necessary, you may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your right to appeal a determination that a service is experimental or investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

- (1) Standard health services are ineffective or medically inappropriate; or
- (2) There does not exist a more beneficial standard service or procedure Covered by Us; or
- (3) There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one (1) of the following:

- (1) A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation — Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- (2) A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- (3) A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

D. Your right to appeal a determination that a service is out-of-network

If We have denied coverage of an out-of-network treatment because it is not materially different from the health service available in network, you may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above and You have requested Preauthorization for the out-of-network treatment.

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

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

E. Your right to appeal an out-of-network referral denial to a non-participating provider

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above.

In addition, your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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

F. Your right to appeal a formulary exception denial

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, you, your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of your plan documents for more information on the formulary exception process.

G. The external appeal process

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

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

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

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, we will Cover the Prescription Drug while You are taking the Prescription Drug.

If your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, we will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of your Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under your Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your responsibilities

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

More information is available upon request

- (1) In accordance with New York law, the following information is available to a member or prospective member upon request by contacting the Member Services department:
- (2) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan
- (3) The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant
- (4) A copy of the most recent individual conversion, direct-pay subscriber contracts
- (5) Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law
- (6) Procedures for protecting the confidentiality of medical records and other enrollee information
- (7) Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs
- (8) Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program
- (9) A description of the procedures followed in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials

- (10) Individual health practitioner affiliations with participating hospitals, if any
Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information the plan might consider in its patient management program; the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan
Member Services can help you with this request by calling the number on your Aetna ID card.
- (11) Written application procedures and minimum qualification requirements for health care providers considered by the plan
- (12) Such other information as required by the Superintendent of Insurance provided that such requirements are promulgated pursuant to the state administrative procedure act
- (13) If you are scheduled to receive health care services, you can ask us if that health care provider participates in the plan's network
- (14) The approximate dollar amount the plan will pay for a specific out-of-network health care service. This information is nonbinding and the approximate dollar amount for a specific out-of-network service may change.

What is “balance billing” (sometimes called “surprise billing”)?

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#) or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars, depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or hospital, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in a stable condition.

Your rights and protections against surprise medical bills

This notice explains how you can get help with unexpected bills from out-of-network providers. This applies to members enrolled in health plans subject to New York regulations. Check your plan documents for more details on balance bills. You can also call Member Services at the toll-free number on your ID card.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist and intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections. You **can't** give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge or unforeseen medical services were provided.

Services referred by your in-network doctor

Surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website at [DFS.NY.gov](https://dfs.ny.gov)) for the full balance billing protection to apply.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your Explanation of Benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, follow the steps below to notify us or contact the New York State Department of Financial Services at [\(800\) 342-3736](tel:8003423736) or surprisemedicalbills@dfs.ny.gov. Visit [DFS.NY.gov](https://dfs.ny.gov) for information about your rights under state law.

(1) Tell us if you had a New York Surprise Bill Complete the New York State Surprise Bill Certification form (previously Assignment of Benefits) if you got a surprise balance bill. The form is:

- › Attached to this notice
- › On the New York Department of Financial Services website at [DFS.NY.gov](https://dfs.ny.gov)
- › On [Aetna.com](https://www.aetna.com) under our state-specific legal notices

(2) How to send us send a Surprise Bill Certification form

- a. Through your member website:
Log in to your secure member website at [Aetna.com](https://www.aetna.com).
Click “Contact Us” in upper right corner. Attach your form and bill.
Click submit.
- b. Mail it to us on the Aetna® address on your ID card.
- c. Mail it to us at:
Aetna
Member Correspondence Unit PO
Box 981106
El Paso, Texas 79998-1106

(3) Tell your provider this is a New York surprise bill

Send a copy of your Surprise Bill Certification form to your provider. This alerts the office not to bill you over your in-network cost share.

(4) What happens after Aetna gets my Surprise Bill Certification form?

- We'll review the balance over your network cost share (copayment, deductible or coinsurance).
- We will send you an Explanation of Benefits (EOB) if we pay more to the provider, your cost share won't increase. You will only owe the cost share shown on your initial EOB.
- If we don't settle, the provider may file a fee dispute called Independent Dispute Resolution (IDR).

Emergency services

You only need to pay your network cost share for emergency services. Your plan documents explain how emergency services are defined. Follow the steps in item four above if you get a balance bill over your network cost share for emergency services. We'll handle it following the benefits in your plan documents.

Out-of-network hospital bills when you're admitted after an emergency room visit

Balance billing protections under New York law include inpatient services provided by a physician or hospital following an emergency room visit at an out-of-network hospital.

You can also use the Surprise Bill Certification form to send us your balance bill for these services. The form is attached to this notice.

Independent Dispute Resolution Process (IDR)

Certain fee disputes can be sent to the New York IDR process.

IDR for surprise bills

We or a provider may file IDR.

The IDR application is on the New York Department of Financial Services website, [DFS.NY.gov](https://www.dfs.ny.gov).

The process starts by completing an IDR application and sending it to the New York Department of Financial Services.

The IDR will be reviewed by a state-assigned independent dispute resolution entity (IDRE).

The IDRE will decide if our payment or the provider's fee is more reasonable within 30 days of receiving the IDR application.

If we need to pay more to the provider, your cost share won't increase. You will only owe the cost share shown on your initial EOB.

A member of a self-funded health plan or a patient who does not have insurance may also file IDR on their own.

IDR for emergency services

The following are eligible for IDR:

- Emergency physician services
- Emergency services provided by an out-of-network hospital
- Inpatient services provided by a physician or hospital following an emergency room visit at an out-of-network hospital
- Services by out-of-network providers at in-network ambulatory surgical centers

We or the provider can file IDR following the same steps noted above. A member of a self-funded plan or a patient who does not have insurance may also file IDR on their own. IDR is for services performed in New York. If you get a balance bill for emergency services outside of

New York, you can also send it to us for review. Upon receipt, we'll handle it based upon the benefits of your health plan.

NEW YORK STATE SURPRISE MEDICAL BILL CERTIFICATION FORM

You are protected from surprise medical bills. Your health plan must pay your health care provider, and your provider cannot bill you, except for any in-network cost-sharing.

- This form is required for surprise bills in (1) below for dates of service before 1/1/22 and for surprise bills in (2) below for all dates of service. This form is **NOT** required for surprise bills in (1) below for dates of service on and after 1/1/22 but helps identify when services are a surprise bill.
- Send a copy of this form to your **provider** and **health plan** (include a copy of any bill you received).
- Your provider may complete this form for a surprise bill described in (1) below for dates of service on and after 1/1/22, and your provider must send it to your **health plan**.

A surprise bill is when:

1. You're at an in-network hospital or ambulatory surgical facility and an in-network provider was not available; an out-of-network provider provided services without your knowledge; or you needed unforeseen medical services. Also, you did not choose to receive services from an out-of-network provider instead of from an available in-network provider before you went to the hospital or ambulatory surgical facility. (Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services in an in-network hospital or ambulatory surgical facility are usually a surprise bill.)
2. During a visit with your in-network doctor, an out-of-network provider treats you; your in-network doctor takes a specimen from you and sends it to an out-of-network lab or pathologist; or your in-network doctor refers you to an out-of-network provider (and referrals are required under your health plan). Also, you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your health plan.

I certify to the best of my knowledge that (check one):

- I received services that are a surprise bill as described in (1) or (2) above and I want the provider to seek payment for this bill from my health plan (this is an "assignment") **OR**
- I am a **health care provider**, and the insured received services that are a surprise bill as described in (1) above for dates of service on and after 1/1/22.

| | |
|--|-------------------------------|
| Patient Name: | Date of Service: |
| Patient Mailing Address: | |
| Insurer Name: | Insurance ID No.: |
| Provider Name: | Provider Phone Number: |
| Provider Mailing Address: | |
| Provider Contact Name (if different from provider name) | |
| Provider Contact Email Address: | |
| <p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.</p> | |
| Signature (of patient or provider): | Date signed: |

If you have questions about this form, contact the Department of Financial Services at 1-800-342-3736.

NYS FORM SURPRISE BILL (12/30/21)

Proprietary

| | |
|------------|--|
| Ukrainian | Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862 . |
| Vietnamese | Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . |

NOA-Commercial Fillable-1557-1 6-25

Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.