BENEFIT PLAN

Extraterritorial Riders

Prepared Exclusively for
Northwestern University Postdoctural Fellow Benefit Program

PPO Medical ET Riders

Aetna Life Insurance Company

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

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Northwestern University Postdoctural Fellow Benefit Program
Group Policy No.:	GP-836990
Rider:	California ET Medical
Issue Date:	November 29, 2010
Effective Date:	January 1, 2011

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of California. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of California, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Cancer Screenings *(GR-9N 11-005 01 CA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 annual cervical cancer screening test, including the conventional Pap test, and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral of the insured's health care provider.

Osteoporosis Services *(GR-9N 11-005 01 CA)*

Covered expenses include charges for services related to the diagnosis, treatment, and appropriate management of osteoporosis. The services include all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Important Reminder
Refer to the Summary of Benefits for details about deductibles, coinsurance, benefit maximums and frequency limits if applicable.

Treatment of Infertility *(GR-9N 11-135-01 CA)*

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits *(GR-9N 11-135-01 CA)*

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-authorization by **Aetna**, subject to all the exclusions and limitations of this *Booklet-Certificate*:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet-Certificate* and has a maximum of 6 cycles per lifetime; (in figuring the lifetime maximum, **Aetna** will take into consideration services received while you are covered under a group health plan as defined under the federal law known as ERISA that is offered by your employer through **Aetna** or one of its affiliated companies, or any other insured medical coverage); and
- Intrauterine insemination is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet-Certificate* and has a maximum of 6 cycles per lifetime; (in figuring the lifetime maximum, **Aetna** will take into consideration services received while you are covered under a group health plan as defined under the federal law known as ERISA that is offered by your employer through **Aetna** or one of its affiliated companies, or any other insured medical coverage).

Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services for procedures that are **covered expenses** under this *Booklet-Certificate*.

Eligibility for ART Benefits

To be eligible for ART benefits under this *Booklet-Certificate*, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected.
- Be referred by your **physician** to **Aetna's** infertility case management unit;
- Obtain pre-authorization from **Aetna's** infertility case management unit for ART services by an ART specialist.

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet-Certificate*:

- Up to 3 cycles and subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of any combination of the following ART services per lifetime (in figuring the lifetime maximum, **Aetna** will take into consideration services received while you are covered under a group health plan as defined under the federal law known as ERISA that is offered by your employer through **Aetna** or one of its affiliated companies, or any other insured medical coverage) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the *Schedule of Benefits* section while covered under an **Aetna** plan;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this *Booklet-Certificate*.

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet-Certificate*:

- ART services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

Refer to the *Schedule of Benefits* for details about the maximums that apply to **infertility** services. The **lifetime maximums** that apply to **infertility** services apply differently than other **lifetime maximums** under the plan.

Continuation of Coverage Under California Law After COBRA Coverage is Exhausted *(GR-9N 31-025 01 CA)*

In accordance with California law, if you continued Health Expense Coverage under this Plan in accordance with federal law (PL 99-272-COBRA) for the maximum period for which such continuation is available to you, and if such maximum period is less than 36 months, you may, prior to the date coverage continuation under COBRA terminates, elect to further continue the same Health Expense Coverage for up to 36 months from the date your COBRA continuation of coverage began.

The election must include an agreement to pay premiums. The premiums may be up to 110% of the cost of the Plan (up to 150% if you are disabled pursuant to Title II or Title XVI of the Social Security Act). Premium payments must be continued.

You must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date **Aetna** informs you of any rights under this section. Within 45 days of such election, you must send to **Aetna** the amount required by **Aetna** as the first premium payment.

Coverage will terminate on whichever of the following is the earliest to occur:

- 36 months after your COBRA continuation period began. However, if you have been determined to have been disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage, you must provide notice to your Employer within 60 days of such determination and prior to the end of the 36 month continuation period. Coverage may only be continued if you are determined to be disabled.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage will be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that you are covered under another group health plan. However, continued coverage will not terminate under such time that you are no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The date you become entitled to benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- The month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the Social Security Act that you are no longer disabled.

The Conversion Privilege will be available when coverage is no longer available under this section.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Northwestern University Postdoctural Fellow Benefit Program
Group Policy No.: GP-836990
Rider: Colorado ET Medical
Issue Date: August 14, 2012
Effective Date: June 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Colorado. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Colorado, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Cleft Lip or Palate Treatment *(GR-9N 11-155 02 CO)*

Treatment of Cleft Lip or Palate Cleft Lip/Palate of a Dependent Child
Covered expenses for treatment given to a dependent child for a congenital cleft lip or cleft palate are payable on the same basis as any other **illness**. This includes treatment for any other condition related to or developed as a result of the cleft lip or palate. These covered expenses include:

- Oral surgery and facial surgery. This includes pre-operative and post-operative care performed by a Physician.
- Oral prosthesis treatment (obturators and orthotic devices).
- First installation of partial or full removable dentures or of fixed bridgework, if dentures are not professionally adequate.
- Replacement of dentures or fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.
- Cleft orthodontic therapy.
- Diagnostic services of a physician to find out if and to what extent the child's ability to speak or hear has been lost or impaired.
- Habilitative speech therapy rendered by a Physician that is expected to overcome congenital or early acquired handicaps as well as to restore or improve the child's ability to speak.

An audiologist or speech therapist who is legally qualified will be deemed a **Physician** for the purposes of this section.

Limitations
Not covered under this benefit are charges for:

- Oral prosthesis, dentures or bridgework ordered before the child becomes covered, or ordered while covered but installed or delivered more than 60 days after termination of coverage.
- Services given to treat delays of speech development unless such delays are shown to be caused by cleft lip or cleft palate or any condition related to or developed as a result of cleft lip or cleft palate.
- Speech aids and training in the use of such aids.
- Augumentive (assistive) Communication Systems and training in the use of such systems.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Cleft Lip or Palate Treatment for Dependent Children	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Child Health Supervision Services (Applicable to Dependent children under age 13) *(GR-9N 11-005-01 CO)*
Covered expenses include **physician**-delivered or **physician**-supervised services for a dependent child under 13 years of age even though they are not incurred in connection with an injury or **illness**.

The following charges will be payable when the service is delivered at the intervals and scope show in the Table below:

- A review and written record of the child's complete medical history.
- Physical examination.
- Developmental and behavioral assessment.
- Anticipatory guidance and education.
- Immunizations including diphtheria, haemophilus influenza type B, hepatitus B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization as recommended by the American Academy of Pediatrics.
- Laboratory tests.

All of the above will be in keeping with prevailing medical standards.

Only charges of one **physician** for Child Health Supervision Services performed at birth will be payable and then at approximately each of the following ages:

2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	8 years
9 months	3 years	10 years
12 months	4 years	12 years

Not covered are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services which are for diagnosis or treatment of a suspected or identified injury or **illness**;
- Services not performed by a **physician** or under his or her direct supervision;
- Medicines, drugs, appliances, equipment, or supplies; or
- Dental exams.

Early Intervention Services *(GR-9N 11-155-01)*

Covered expenses for early intervention services, given to a dependent child from birth to 3 years of age, are payable on the same basis as any other **illness**. These services might not be in connection with treatment of an injury or disease. The dependent child must be identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, as amended. You must submit proof of such identification.

Early Intervention Services are services, provided as part of an active individualized family service plan, that enhance functional ability without effecting cure. They include, but are not limited to, the following:

- Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease or injury.
- Assistive technology devices.

Not more than the Early Intervention Services Maximum will be payable, as shown in the Schedule of Benefits. This maximum shall be adjusted based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for the fiscal year in the state-funded early intervention program (if that increase is more than the consumer price index increase).

The Early Intervention Services Maximum shall not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation.

Coverage for **Early Intervention Services** for covered children does not duplicate or replace treatment for autism spectrum disorders. **Early Intervention Services** supplement, but do not replace, autism coverage services.

Benefits shall not be subject to **deductible** or **copayment** and shall not be applied to any applicable annual or lifetime maximum.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Early Intervention Services for Dependent Children from Birth to Age 3	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Maximum Benefit per Calendar Year	$6,249	$6,249	$6,249

Routine Cancer Screenings *(GR-9N 11-005-03 CO)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for a woman 35-40 years of age;
- 1 mammogram every calendar year for women 40 years of age or older;
- 1 cervical cancer immunization for women, up to the age limitations recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services; and
- Prostate specific antigen (PSA) test and digital rectal exam for covered males age 40 and older.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N-S-10-15-01 CO)*			
Routine Mammography	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	80% per visit No Calendar Year **deductible** applies.
Prostate Specific Antigen Test and Digital Rectal Exam For covered males age 40 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Minimum Benefit per Prostate Specific Antigen Test	The plan will pay no less than $65.	The plan will pay no less than $65.	The plan will pay no less than $65.
Cervical Cancer Immunization (applies only to females up to the age limitations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control)	100%	100%	100%
Maximum Number of Immunizations per Lifetime	1	1	1

Colorectal Cancer Treatment

Covered expenses include charges for the treatment for the early detection of colorectal cancer and adenomatous polyps for those who are asymptomatic average risk adults who are 50 years of age or older or if you are at a high risk for colorectal cancer including those who have a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, ulcerative colitis or other predisposing factors as determined by a physician.

Covered expenses shall include the following tests as determined by a physician that detects adenomatous polyps or colorectal cancer modalities that are currently included in an "A Recommendation" or a "B Recommendation" by the U.S. Preventive Services task force or any successor organization sponsored by the Agency for Health Care Research and Quality, the Health Services Research Arm of the Federal Department of Health and Human Services.

For purposes of this section, an "A Recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

a) found good evidence that the preventive health care service improves important heath outcomes; and
b) concluded that the benefits of the preventive health care service substantially outweigh its harm.

A "B Recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

a) found at least fair evidence that the preventive health care service improves important heath outcomes; and
b) concluded that the benefits of the preventive health care service outweigh its harm.

Covered expenses shall not be subject to the **deductible**, if applicable.

Physician Services *(GR 9N 11-20 02 CO)*

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment,
- Allergy testing and allergy injections; and
- Services appropriately provided via telephone (also known as Telemedicine) if you reside in a county of 150,000 residents

Pregnancy Complications *(GR-9N 11-100 01 IL)*

Covered expenses include charges made in connection with pregnancy complications of a covered female employee only. Pregnancy complications means:

- Conditions (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity,
- A non-elective cesarean section, ectopic pregnancy, which is termination and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Limitations

Not covered under this benefit are charges made for a routine pregnancy including prenatal visits, delivery and post natal visits.

A scheduled or non-emergency cesarean delivery is not considered a pregnancy complication under this Plan.

False labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct completion of pregnancy are not considered pregnancy complications under this Plan.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Clinical Trials

A clinical trial is an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

Routine patient care costs are a covered expense if:

(I) your treating physician, who is providing covered health care services to you recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit;

(II) the clinical trial or study is approved under the September 19, 2000 Medical National Coverage Decision Regarding Clinical Trials, as amended;

(III) your care is provided by a certified, registered or licensed health care provider practicing with the scope of their practice and the facility and personnel providing the treatment have experience and training to provide the treatment in a competent manner;

(IV) prior to participation in a clinical trial or study, you signed a statement of consent indicating that you were informed of the procedure to be undertaken, alternative methods of treatment and the general nature and extent of the risks associated with participation in the clinical trial or study, the Covered Expenses will be consistent with the coverage provided by the Group Policy and this Certificate; and

(V) you suffer from a condition that is disabling, progressive or life-threatening.

Routine care costs include:

- all items and services that a benefit under the Group Policy and this Certificate would be covered if you were not involved in either the experimental or the control arms of a clinical trial; except the investigation item or service, itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial;
- routine costs in clinical trials that include items and services that are typically provided absent a clinical trial;
- items or services required solely for the provision of the investigation items or services, the clinically appropriate monitoring of the effects of the item or service or the prevention of complications; and
- items or services needed for reasonable and necessary care arising from the provision of an investigation item or service, including the diagnosis or treatment of complications.

Limitations

Not included under this clinical trial benefit are charges incurred for:

(I) any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical or medical industry;

(II) any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;

(III) extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that a participant or person accompanying the participant may incur;

(IV) an item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

(V) costs for the management or research relating to the clinical trial or study; or

(VI) health care services, that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy and this Certificate.

Experimental or Investigational *(GR-9N-34-025-04 CO)*

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by the treating facility or by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment

  that states that it is **experimental or investigational**, or for research purposes.

Inherited Enzymatic Disorder *(GR-9N 13-005-03 CO)*
Care and treatment of inherited enzymatic disorders shall include, to the extent medically necessary, medical foods for home use for which a physician who is a network provider has issued a written, oral or electronic prescription. Inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions. Phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic academia and propionic academia.

There is no age limit on benefits for the above inherited enzymatic disorders; except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is 21 years of age; except that the maximum to receive benefits for phenylketonuria for women who are of child bearing age is 35 years of age.

"Medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids for which medically standard methods of diagnosis, treatment and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a network provider. Coverage shall only be available through a network pharmacy.

Hospital *(GR-9N 34-040-01 CO)*
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations; and
- Is currently licensed or certified by the Colorado Department of Health and Environment.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Converting to an Individual Medical Insurance Policy *(GR-9N 31-040 01 CO)*

Eligibility
You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by **Aetna** when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are covered under Medicare (Title XVIII of the Social Security Act, as amended).
- Coverage under the plan has been in effect for less than three months.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Continuing Coverage *(GR-9N 31-015-01 CO)*

If your coverage would terminate for any reason except:

- Health Expense Coverage discontinues as to your eligible class; or
- You fail to make the required contributions;
- You become eligible for Medicare;

you may continue any health coverage (except Dental, Vision and Prescription Drug Expense Coverage) then in force for you and your dependents; but, only if you have been covered under this Plan or under this Plan and any prior plan for at least 6 months in a row.

You have to make request in writing for this continuation. It must be done within 31 days of the date your coverage would otherwise stop. Premium payments must be made.

Coverage will stop on the earlier of:

- The end of the 180 day period which starts on the date coverage would otherwise end.
- The date you are employed by any employer.
- The date you fail to make the required contributions.
- The date health coverage discontinues as to employees of your former eligible class.
- The date you became eligible for like group coverage. If you have a preexisting condition or any other condition covered under this Plan but for which coverage is not available under the like coverage, this will not apply unless and until coverage is available under the like group coverage.
- Coverage for a dependent will end earlier when the dependent ceases to be a defined dependent.

Important Note
If any coverage being continued ceases, you may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Northwestern University Postdoctural Fellow Benefit Program
Group Policy No.:	GP-836990
Rider:	Missouri ET Medical
Issue Date:	November 29, 2010
Effective Date:	January 1, 2011

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Missouri. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Missouri, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Child Health Supervision Services Expenses *(GR 9 NS 11-190)*

The charges below are included as **covered expenses** even though they are not incurred in connection with an **illness** or **injury**. They are included only for a dependent child under 13 years of age. Benefits are payable on the same basis as any other sickness.

Child Health Supervision Services Expenses are the charges for Child Health Supervision Services.

"Child Health Supervision Services" means **physician**-delivered or **physician**-supervised services which shall include coverage for services delivered at the intervals and scope stated below. Included are:

- A review and written record of the child's complete medical history.
- Physical examination.
- Developmental and behavioral assessment.
- Anticipatory guidance and education.
- Immunizations including diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization as recommended by the American Academy of Pediatrics.
- Laboratory tests.

All of the above will be in keeping with prevailing medical standards.

Covered expenses will only include charges of one physician for Child Health Supervision Services performed at birth and at approximately each of the following ages:

2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	8 years
9 months	3 years	10 years
12 months	4 years	12 years

Not covered are charges incurred for:

- services which are covered to any extent under any other part of this Plan;
- services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- services not performed by a physician or under his or her direct supervision;
- medicines, drugs, appliances, equipment, or supplies; or
- dental exams.

Routine Cancer Screenings *(GR 9 NS 11-005 MO)*

Covered expenses include charges incurred for routine cancer screening as follows:

Mammogram Expense Benefit

Covered expenses include charges incurred by covered persons for mammograms. The charges must be incurred while a covered person is insured for these benefits. Benefits are payable on the same basis as any other radiological examinations covered under this plan.

Benefits will be paid for expenses incurred for the following:

(1) A baseline mammogram for women between the ages of 35 through 39, inclusive; and
(2) A mammogram every two years; or more frequently based on the recommendation of the women's physician for women ages 40 through 49;
(3) A mammogram on an annual basis for women 50 years of age and older;
(4) A mammogram for any women, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer.

Pelvic Examination Pap Smear Expense Benefit

Covered expenses include charges incurred by a covered person for a pelvic examination and pap smear test for cancer, for any non-symptomatic woman, in accordance with current guidelines of the American Cancer Society. Benefits are payable on the same basis as any other sickness.

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 Pap smear every 12 months; and
- 1 gynecological exam every 12 months. This includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer.

Prostate Cancer Screening Expense

Covered expenses include charges incurred by a covered person for a prostate examination and laboratory tests for any non-symptomatic man, in accordance with current guidelines of the American Cancer Society. Benefits are payable on the same basis as any other sickness.

Routine Colorectal Cancer Screening Expense

Covered expenses include charges incurred by a covered person for colorectal cancer examination and laboratory tests in accordance with the current guidelines of the American Cancer Society. Benefits are payable on the same basis as any other sickness.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Cancer Coverage – Second Opinion

Covered expenses include coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Benefits are payable on the same basis as any other sickness.

Alcoholism and Substance Abuse *GR-9N 11-175 02 MO)*

Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by **behavioral health providers**. Benefits are payable on the same basis as for any other illness. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse**.

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse**.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of alcoholism **or substance abuse** up to a maximum of 30 days of inpatient care.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital**, when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse
The plan covers outpatient treatment of alcoholism **or substance abuse**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Coverage is limited to:

- 2 sessions per year with a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker;
- 26 days per policy benefit period in a non-residential treatment program, or a partial or full day program;
- 21 days per befit period in a residential treatment facility;
- up to 6 days of treatment for detoxification.

a lifetime maximum of 10 episodes of treatment, except that the lifetime maximum does not apply to medical detoxification in a life-threatening situation as determined by the treating physician.

Important Reminder
Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Experimental or Investigational Treatment *(GR-9N 11-195 01 MO)*

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

Covered expenses also include **Routine Patient Care Costs** as the result of a phase III or IV of a clinical trial that is approved or funded by an Official Entity and is undertaken for the purposes of the prevention, early detection or treatment of cancer.

Covered expenses also include **Routine Patient Care Costs** as the result of a phase II clinical trial undertaken for the purposes of the prevention, early detection or treatment of cancer. Phase II of a clinical trial must be sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and the patient must be enrolled in the clinical trial and not only following the protocol of a phase II clinical trial, but not actually enrolled.

The plan limits coverage for the **Routine Patient Care Costs** of patients in phase II of a clinical trial to those treating facilities within the **Aetna** benefit plans' provider network; except that, this provision shall not be construed as relieving the plan of the sufficiency of network requirements under Missouri law.

Routine Patient Care Costs for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services to administer the drug or use the device under evaluation in the clinical trial.

Routine Patient Care Costs do not include: (a) The investigational item or service itself; (b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

The treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Official Entity, for purposes of phase III and IV of a clinical trial, is one of the following entities:

1. One of the National Institutes of Health (NIH);
2. An NIH cooperative group or center - as defined by Missouri law is a formal network of facilities that collaborate on research projects and have an established NIH- approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
3. The FDA in the form of an investigational new drug application;
4. The federal Departments of Veterans' Affairs or Defense;
5. An institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
6. A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Early Intervention Services Expenses *GR 9 NS 11-005MO)*

The charges below are included as Covered Medical Expenses even though they may not be incurred in connection with an injury or disease. They are included only for: a dependent child from birth to 3 years of age, who is identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, as amended. You must submit proof of such identification with the initial claim.

Early Intervention Services Expenses
These are the charges incurred for Early Intervention Services.

Early Intervention Services
These are services, provided as part of an active individualized family service plan, that enhance functional ability without effecting cure. They include, but are not limited to, the following:

- Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease, or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease, or injury.
- Assistive technology devices.

Not more than the Early Intervention Services Calendar Year Maximum will be payable for Early Intervention Services Expenses incurred by a person in any one calendar year.

Not more than the Early Intervention Services Lifetime Maximum will be payable for Early Intervention Services Expenses incurred by a person during the person's lifetime.

Early Intervention Services	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Child Early Intervention Services *(GR-9N-S-10-010-03 IL)*

Calendar Year Maximum	$3,000	$3,000	$3,000
Aggregate Maximum over total 3 year period	$9,000	$9,000	$9,000

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Northwestern University Postdoctural Fellow Benefit Program
Group Policy No.: GP-836990
Rider: Washington ET Medical
Issue Date: November 29, 2010
Effective Date: January 1, 2011

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Washington. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Washington, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent through marriage.
- You elect coverage for yourself and your dependent within 60 days of acquiring a dependent through birth, adoption or placement for adoption.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

If the special enrollment will result in additional premiums, you will need to report any new dependents by completing a change form, which is available from your policyholder. The form must be completed and returned to Aetna within 31 days of the change for the addition of a spouse, and 60 days for the addition of a dependent child, by birth, adoption, or placement with you for adoption. If you do not return the form within these timeframes, you will need to make the changes during the next open enrollment period unless you qualify for another special enrollment period.

Mammograms

- 1 mammogram every 12 months for covered females age 40 and over; or as recommended by your treating **health care provider.**

Neurodevelopmental Therapy

Occupational therapy, speech therapy and physical therapy delivered to covered dependents age six and under for the maintenance of the dependent's functioning in cases where significant deterioration in the his or her condition would result without the service or to restore and improve function.

Home Health Care

Covered expenses include charges made by a **home health care agency** for home health care, when you have consented to home health care as an alternative to inpatient care and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**; and
- Is in lieu of a stay in a **hospital** or other inpatient facility.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N**.;
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**;
- Physical, occupational, and speech therapy;
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**; and
- Medical supplies, **durable medical equipment, prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had continued your **hospital stay**.

Benefits for home health care visits are payable up to the home health care maximum shown in the *Schedule of Benefits***.** Each visit by a nurse or therapist is one visit.

In figuring the home health care maximum visits, each visit of up to 4 hours is one (1) visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, covered medical expenses include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for home health care services does not include **custodial care**. The need for a caregiver to perform a non-skilled or **custodial care** service does not cause the service to become a **covered expense** under this plan. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled or **custodial care** needs.

Note:

Home short-term physical, speech, or occupational therapy is covered when home health care is provided in lieu of inpatient care.

Limitations
Unless expressly provided in the home health care benefit description above, the following are ***not*** **covered expenses:**

- Services or supplies that are not a part of the **home health care plan**;
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family;
- Services of a certified or licensed social worker;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
- Services that are **custodial care**.

Important Reminders

- The plan does ***not*** cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.
- Home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.
- Refer to the *Schedule of Benefits* for details about home health care visit maximums.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses
Covered expenses include charges made on an outpatient basis by a **hospice care agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.**;
- Part-time or intermittent home health aide services to care for you in accordance with the approved treatment plan;
- Medical social services under the direction of a **physician** or **other health care provider**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy;
- Consultation or case management services by a **physician** or **other health care provider**;
- Medical supplies;
- **Prescription drugs**;
- Dietary counseling; and
- Psychological counseling; and
- Respite care that is continuous in the most appropriate setting for a maximum of 5 days per 3 month period of **Hospice Care**.

Covered expenses also include charges made by the providers below if they are not an employee of a **hospice care agency** and such agency retains responsibility for your care:

- A **physician** or other **health care provider** for a consultation or case management;
- A physical or occupational therapist; and
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care as set forth in the approved treatment plan;
  - Medical supplies;
  - **Prescription drugs**;
  - **Durable medical equipment (DME)** which would have been provided in an inpatient setting;
  - Psychological counseling; and
  - Dietary counseling.

Limitations
Unless specified above, charges for the following are not **covered expenses**:

- Daily **room and board** charges over the **semi-private room rate**;
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling (this includes estate planning and the drafting of a will); and
- Homemaker or caretaker services; these are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members, transportation, and maintenance of the house.

Important Reminders

- Refer to the *Schedule of Benefits* for details about **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**

Acupuncture

The plan covers charges made for acupuncture services provided by a **health care provider**, within the scope of his or her license, if the service is performed:

- As a form of anesthesia in connection with covered surgery; or
- To treat an **illness**, **injury** or alleviate chronic pain.

Physician
A duly licensed member of a medical profession who:

- Has a Medical Doctor (M.D.) or Doctor of Osteophopathy (D.O.) degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction within which he or she practices;
- Provides medical services which are within the scope of his or her license or certificate, and
- Is not any person who resides in your home; or who is a member of your family, or a member of your spouse's family or your domestic partner.

Continuation of Coverage During a Labor Dispute

If your coverage under this plan would cease because you cease work due to a strike, lockout or other labor dispute, you can arrange to continue your coverage during your absence from work. You may make the premium payments to your employer. Your employer will transmit the payments to **Aetna**. Call the Member Services toll free number on you ID card for information on the premium payment process. Coverage may continue for up to 6 months. At the end of 6 months you will be eligible for Conversion Coverage.

Continuation will cease when the first of these events occurs:

- You fail to make the required contributions;
- You go to work full time for another employer;
- The labor dispute ends; or
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable effective rate in effect on the date you cease work. If the premium paid by your employer changes during the time you are continuing coverage under this provision, your premiums will change correspondingly.

Coordination of Benefits

Benefits Subject To This Provision: This coordination of benefits (COB) provision applies to **this plan** when you or your covered dependent has medical, dental, vision, or hearing coverage under more than one **plan.** "**Plan**" and "**this plan**" are defined herein. The order of benefit determination rules below determines which **plan** will pay as the **primary plan**. The **primary plan** pays first without regard to the possibility that another **plan** may cover some expenses. A **secondary plan** pays after the **primary plan** and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total **allowable expense**.

Definitions. When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means any health care expense for any **medically necessary** health care service or supply, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the **plans** covering the person. When a **plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. **This plan** limits coordination of health care services or expenses with those services or expenses that are covered under similar types of **plans,** (for example, Medical coverage is coordinated with another Medical **plan**). An expense or service that is not covered by any of the **plans** is not an **allowable expense**. This plan does not coordinate benefits for **prescription drugs**. The following are examples of expenses and services that are not **allowable expense**s:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **plans** provides coverage for a private room.
2. If a person is covered by 2 or more **plans** that compute their benefit payments on the basis of **UCR charges** or relative value schedule reimbursement or other similar reimbursement method, any amount in excess of the highest of the reimbursement amount for a specified benefit is not an **allowable expense**.
3. If a person is covered by 2 or more **plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest negotiated charges is not an **allowable expense**.
4. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan's deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Claim Determination Period. A calendar year.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation. In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater resident time is awarded is considered the **custodial parent**.

Plan. Any **plan** providing benefits or services by reason of medical, dental, vision or hearing care or treatment, which benefits or services are provided by one of the following:

- Group, individual or blanket disability insurance contracts, and group or individual contracts;
- Closed panel plans or other forms of group or individual coverage;
- The medical care components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits as permitted by law.

Plan does not include:

- Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined in WAC 284-50-370;
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for non medical services;
- Medicare Supplement policies;
- A state plan under Medicaid;
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan'
- Benefits provided as part of a direct agreement with a direct patient-provider primary care practice' and
- Automobile insurance policies required by statute to provide medical benefits.

If the **plan** includes medical, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, medical coverage will be coordinated with other medical **plans**, and dental coverage will be coordinated with other dental **plans**. This **plan** does not coordinate coverage for **prescription drugs**.

This plan is any part of the policy that provides benefits for health care expenses.

Primary plan/secondary plan. The order of benefit determination rules state whether **this plan** is a **primary plan** or **secondary plan** as to another **plan** covering the person.

- When **this plan** is a **primary plan**, its benefits are determined before those of the other **plan** and without considering the other **plan's** benefits. A **plan** is considered the **primary plan** if it either has no order of benefit determination rules, or if its rules differ from those permitted by Washington State regulations.
- When **this plan** is a **secondary plan**, its benefits are determined after those of the other **plan** and may be reduced because of the other **plan's** benefits. When coordinating benefits, any **secondary plans** must pay an amount which, together with the payment made by the primary plan, totals the higher of the **allowable expenses**. In no event will a **secondary plan** be required to pay an amount in excess of its maximum benefit plus accrued savings.
- When there are more than two **plans** covering the person, **this plan** may be a **primary plan** as to one or more other **plans**, and may be a **secondary plan** as to a different **plan** or **plans**.

Order of Benefit Determination
When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.
- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:
  1. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, covered person, subscriber or retiree is primary and the **plan** that covers the person as a dependent is **secondary**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, covered person, subscriber or retiree is secondary and the other **plan** is primary.
  2. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:
     A The **primary plan** is the **plan** of the parent whose birthday occurs earlier in each calendar year if:
     - The parents are married or living together whether or not married;
     - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

     B If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.
     - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
       - The **plan** of the **custodial parent**;
       - The **plan** of the spouse of the **custodial parent**;
       - The **plan** of the non-**custodial parent**; and then
       - The **plan** of the spouse of the non-**custodial parent**.

     For a dependent child covered under more than one **plan** of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
  3. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
  4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, covered person, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, covered person, or subscriber longer is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of a plan's benefits; a change in the entity that pays, provides, or administers the plan's benefits; or a change from one type of plan to another, such as from a single employer plan to a multiple employer plan.
6. If the preceding rules do not determine the **primary plan**, the **allowable expense**s shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **this plan** will not pay more than it would have paid had it been **primary** plus any accrued savings.

Effect on Benefits of This Plan
In determining the amount to be paid when this plan is secondary on a claim, the **secondary plan** will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any **allowable expense** under this plan that was unpaid by the **primary plan**. The amount will be reduced so that when combined with the amount paid by the **primary plan**, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total **allowable expense**.

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **this plan**, the amount normally reimbursed for covered benefits or expenses under **this plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **this plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **this plan** and another plan both agree that **this plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plan**s COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans

When a **plan** is the **secondary plan**, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a **claim determination period** do not exceed one hundred percent of the total **allowable expenses**. The **secondary plan** must calculate its savings by subtracting the amount that it paid as a **secondary plan** from the amount it would have paid had it been **primary**. These savings are recorded as a benefit reserve for the covered person and must be used by the **secondary plan** to pay any **allowable expenses** not otherwise paid, that are incurred by the covered person during the **claim determination period**. As each claim is submitted, the issuer of the **secondary plan** must:

- Determine its obligation under its **plan**;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that **claims determination period**.
- Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

Multiple Coverage Under Aetna Plans
If a person is covered under **this plan** and another **Aetna** plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

- The person's coverage in each capacity under **this plan** and the other **Aetna** plan will be set up as a separate "**plan**".
- The order in which various **plans** will pay benefits will apply to the "**plans**" set up above and to all other **plans**.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this **plan.**

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this **plan** and other **plans**. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment
Any payment made under another **plan** may include an amount which should have been paid under **this plan**. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under **this plan**. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claims, Appeals, Grievances, Independent Medical Review

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Written notice of Adverse Benefit Determinations, including the reasons for the determination, will be provided to you and your provider according to the time frames given below. The notice will include information which will assist you in making an appeal if you wish to do so.

In Washington State, an **adverse benefit determination** is either:

- An "**adverse determination and noncertification**" which means a decision to deny, modify, reduce, or terminate payment for, coverage of, authorization of or provision of health care services or benefits including the admission to or continued stay in a facility"; or
- A decision that a service or benefit is not covered for other reasons including, but not limited to, member not eligible for coverage at time service is provided, benefit maximums under the plan have been reached, or the service or supply is not covered under the plan.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received. Refer to the *How the Plan Works, "Understanding Precertification"* section for additional information about when you or your **health care provider** must make **pre-service claims**.

Post-Service Claim: Any claim that is not a "**Pre-Service Claim**", "**Urgent Care Claim**" or a "**Concurrent Care Claim**".

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

You or **"the claimant"**. For purposes of this amendment "you" also means "you ***or*** your attending **health care provider** or the facility making the claim on your behalf".

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of an **urgent care** claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **health care provider** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

If no additional information is required **Aetna** will make a claim determination as soon as possible but not later than 2 business days after the claim is made. **Aetna** will provide notification 2 calendar days after the **pre-service claim** determination is made. **Aetna** may determine that an extension is needed because **Aetna** needs additional information to make a claim determination**. Aetna** will notify you within 15 calendar days from receipt of a **pre-service claim** if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will make the claim determination within 2 business days of receipt of all necessary information and will provide notification to the member and the attending **health care provider** or ordering provider or facility within 2 calendar days of the determination.

Post-service Claims

If all information necessary to evaluate a claim is provided when the **post service claim** is received, **Aetna** will make notification of a claim determination as soon as possible but not later than 30 calendar days after the **post-service claim** is made. **Aetna** may determine that we need additional information in order to make a claim determination, in which case we may request an extension. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. The notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information. **Aetna** will not retrospectively deny coverage for **precertified** care including **precertified prescription drugs**, if covered.

Concurrent Care Claim Extension
Following a request for **a concurrent care claim extension**, **Aetna** will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, **Aetna** will make a determination within 14 days following a request for a concurrent care claim extension and will provide notification within one day of the determination.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**, but in no event will the timeframe for the notification be longer than one day. If you choose to appeal **Aetna**'s determination, **Aetna** will continue to provide the previously approved course of treatment until the **appeal** is resolved, including Independent Medical Review if requested. If **Aetna**'s decision is affirmed then you will be responsible for the cost of the services provided after the termination date provided in the notification.

Notification of Adverse Determination and Noncertification
Notifications of claim determinations which include an **adverse determination and noncertification** will include the actual reasons for the determination, instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. Notifications of an **adverse determination and noncertification** are provided to you and the treating **health care provider** or facility making the claim.

Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or write Aetna Customer Service within 180 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a notification of receipt of your **complaint** within 5 days, and a written response within 14 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your **complaint**, **Aetna** will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the **complaint**. **Aetna** will not take longer than 30 days to respond to your **complaint** without your written permission. The notice of the decision will tell you what you need to do to request an External Review.

Appeals of Adverse Benefit Determinations
You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days with respect to Group Health claims following the receipt of notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** may be submitted orally or in writing and should include:

- Your name;
- Your policyholder's name;
- A copy of **Aetna**'s notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID card.

Alternatively, you may send your **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the toll-free telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to **Aetna**.

An **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**. You may request assistance making your **appeal** by calling the toll free customer service number listed on your ID card. **Aetna** will send you notification that your **appeal** has been received.

Appeal Response Times

Urgent care claims (may include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-service claims (may include concurrent care claim reduction or termination)
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the **appeal**. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the **appeal** period. For **appeals** of claims decisions based on the determination that the requested treatment, service or supply is **experimental or investigational**, **Aetna** will issue a decision within 20 working days.

Post-Service Claims
Aetna shall issue a decision within 14 calendar days of receipt of the request for an **appeal** unless additional information is necessary to complete review of the **appeal**. You will be notified within the initial 14 day period if additional information is necessary. **Aetna** will make a decision on the claim within 30 days of the receipt of the claim, unless we have your written consent to extend the **appeal** period.

Exhaustion of Process

You are encouraged to exhaust the applicable process of the Appeal Procedure before you:

- contact the Office of the Insurance Commissioner to request an investigation of a **complaint** or **appeal**; or
- file a **complaint** or **appeal** with the Office of the Insurance Commissioner; or
- initiate any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review Group Health Claims
If you do not agree with **Aetna's** decision of your **appeal**, or if **Aetna** takes longer than 30 days from the date of receipt of your **appeal** to reach a decision without your written consent, you or your provider may request an independent external review. An external review is a review by an External Review Organization, who assigns a reviewer with expertise in the problem or question involved to review your request and reach an independent decision.

The **appeal** denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to **Aetna** within 180 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization, according to the requirements of Washington Law, which will conduct the review of your claim and not later than the third business day after the date we receive your request for external review, will forward the required documents, including the material you sent to us to the External Review Organization. You may request a copy of the material we send, and we may request a copy of any additional material your or your treating provider send to the External Review Organization.

The External Review Organization will select an independent **physician** or contract specialist with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow **Aetna**'s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of **Aetna**'s receipt of your request form and all necessary information. A quicker review is possible if your **health care provider** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of sending the information that was used to make the initial determination and the claim determination, and any information from you or your provider to the External Review Organization and for the cost of the external review. You are responsible for the cost of compiling and sending documentation other than medical records that you wish to be reviewed by the External Review Organization to **Aetna**.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)