BENEFIT PLAN

Prepared Exclusively for
University of Pennsylvania Postdoctoral Insurance Plan

Open Choice (PPO Medical Plan)

Extraterritorial Riders

Aetna Life Insurance Company

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

aetna SM

Table of Contents

Aetna Life Insurance Company

Hartford, Connecticut 06156

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

Policyholder:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Alabama ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Alabama. **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 Alabama, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Pharmacy Benefit Limitations *(GR-9N-S-13-15-01) (GR-9N 13-015-01 AL)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Arizona ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Arizona. **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 Arizona, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

Family Planning Services *(GR-9N-11-005-01 AZ)*

Covered expenses include charges for certain contraceptive services even though not provided to treat an **illness** or **injury**.

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.

References to subrogation, if any, have been removed from the *General Provisions* section of your Booklet-Certificate and no longer apply to your plan of benefits.

Appeals Procedure – Health Care Coverage *(GR-9N-32-050-01-AZ)*

Getting Information about the Health Care Appeals Process

We must send you a copy of the Arizona Appeals Information Packet when you first receive your policy, and within 5 business days after we receive your request for an **appeal**. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of the Arizona Appeals Information Packet. We will also send a copy of the Arizona Appeals Information Packet to you or your treating **provider** at any time upon request. To request a copy, just call the Member Services number printed on your Member ID Card.

At the back of the Arizona Appeals Information Packet, you will find forms you can use for your **appeal**. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care **appeal**. You are not required to use them. We cannot reject your **appeal** if you do not use them. If you need help in filing an **appeal**, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602-364-2499 or 1-800-325-2548 (inside Arizona but outside the Phoenix area), or via the internet at http://www.azinsurance.gov, or you may call us at 1-800-756-7039.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to **appeal** that decision. Your notice may come directly from us, or through your treating **provider**.

Decisions You Can Appeal

You can **appeal** the following decisions:

1. We do not approve a service that you or your treating **provider** has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary".
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.
7. You disagree with our decision to issue or not issue a policy to you.

Decisions You Cannot Appeal

You cannot **appeal** the following decisions:

1. You disagree with our decision as to the amount of "usual, customary, and reasonable charges". Where applicable, a usual, customary, and reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the **provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the usual, customary, and reasonable charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of **provider**s in the area.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your Plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You are dissatisfied with any rate increases you may receive under your insurance policy.
6. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling our Customer Services Department at the number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018.

Who Can File an Appeal

Either you or your treating **provider** can file an **appeal** on your behalf. At the end of the Arizona Appeals Information Packet is a form that you may use for filing your **appeal**. You are not required to use this form. If you wish, you can send us a letter with the same information. If you decide to **appeal** our decision to deny authorization for a service, you should tell your treating **provider** so the **provider** can help you with the information you need to present your case.

DESCRIPTION OF THE APPEALS PROCESS

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of **appeal** has three levels, as follows:

Expedited Appeals (For urgently needed service you have claims)	**Standard Appeals** (For non-urgent services or denied not yet received)
Level One: Expedited Medical Review	Informal Reconsideration
Level Two: Expedited Appeal	Formal Appeal
Level Three: Expedited External, Independent Medical	External, Independent Medical Review

We make the decisions at Level One and Level Two. An outside reviewer, who is completely independent from Aetna, makes Level Three decisions. You are not responsible to pay the costs of the external review if you choose to **appeal** to Level Three. These three levels of Appeals are discussed more fully below:

Before requesting a level three, you must exhaust the internal **appeal** process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal **appeal** process except failures that are based on *de minimis* violations
- You request a simultaneous expedited internal and external **appeal**.

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review (Level One)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us;
- We denied your request for a covered service; and

- Your treating **provider** certifies that the time required to process your request through the Informal Reconsideration (Level One) and Formal Appeal (Level Two) **appeal** process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of the Arizona Appeals Information Packet is a form that your **provider** may use for this purpose. Your **provider** could also send a letter or make up a form with similar information.) Your treating **provider** must send the certification and documentation to:

  Name: Aetna Life Insurance Company
  Title: Customer Resolution Team
  Address: P.O. Box 14002, Lexington, KY 40512

  Phone: 1-877-665-6736
  Fax: 860-754-5321

Our Decision: We must call and inform you and your treating **provider** of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating **provider**. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately **appeal** to Level Two.

If we grant your request: We will authorize the service and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Expedited Appeal (Level Two)

Your request: If we deny your request at Level One, you may request an Expedited Appeal. After you receive our Level One denial, your treating **provider *must immediately*** send us a request (to the same person and address listed above under Level One) to tell us you are appealing to Level Two. To help your **appeal**, your **provider** should also send us any more information that the **provider** hasn't already sent us to show why you need the requested service.

Our Decision: We must call and inform you and your treating **provider** of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating **provider**. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately **appeal** to Level Three.

If we grant your request: We will authorize the service and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Informal Reconsideration (Level One)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited **appeal**, and
- You or your treating **provider** asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name: Aetna Life Insurance Company
Title: Customer Resolution Team
Address: P.O. Box 14002, Lexington, KY 40512

Phone: 1-800-545-2211
Fax: 859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating **provider** a notice that we received your request.

Our decision: Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same timeframe, we must send you and your treating **provider** our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 60 days to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension--within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 60 days to appeal to Level Two.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 60 days to appeal to Level Two**.

If we grant your request: The decision will authorize the service or pay the claim and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

You must exhaust the internal **appeal** process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal **appeal** process except for failures that are based on unimportant or minor violations

Formal Appeal (Level Two)

Your request: You may request Formal Appeal if we denied your request or claim at Level One. After you receive our Level One denial, you or your treating **provider** must send us a written request within 60 days to tell us you are appealing to Level Two. To help us make a decision on your **appeal**, you or your treating **provider** should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

A Member and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. The hearing will be informal. A Member's Physician or other experts may testify. Aetna also has the right to present witnesses.
Send your **appeal** request and information to:

Name: Aetna Life Insurance Company
Title: Customer Resolution Team
Address: P.O. Box 14002, Lexington, KY 40512

Phone: 1-800-545-2211
Fax: 859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating **provider** a notice that we received your request.

Our decision: For a denied service that you have not yet received, Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service. We will send you and your treating **provider** our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have four months to appeal to Level Three.**

If we deny your request for a Concurrent Care Claim Extension--within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have four months to appeal to Level Three.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have four months to appeal to Level Three**.

If we grant your request: We will authorize the service or pay the claim and the **appeal** process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

II. The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any Member who files a Complaint or Appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, you must pursue the health care Appeals process before the Director of Insurance can investigate a Complaint or Appeal you may have against Aetna based on the decision at issue in the Complaint or Appeal.

The Appeal process requires the Director to:

1. Oversee the Appeals process.
2. Maintain copies of each utilization review Plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for External Independent Medical Review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an Appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

III. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits the Member to ask for a copy of their medical records. Your request must be in writing and must specify who you want to receive the records. The health care **Provider** who has your records will provide you or the person you specify with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to you or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the Appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

IV. Documentation for an Appeal

If you decide to file an Appeal, the Member must give us any material justification or documentation for the Appeal at the time the Appeal is filed. If you gather new information during the course of your Appeal, you should give it to us as soon as you receive it. You must also give Aetna the address and phone number where you can be contacted. If the Appeal is already at Expedited External Independent Medical Review, you should also send the information to the Department of Insurance.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (your last known address) on the fifth business day after being mailed.

VI. Record Retention

Aetna shall retain the records of all Complaints and Appeals for a period of at least 7 years.

VII. Fees and Costs

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a Member in pursuing a Complaint or Appeal.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Member Services. The complaint 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 written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including Plan limitations or exclusions.

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

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

External Independent Review *(GR-9N-32-051-01-AZ)*

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited External, Independent Review (Level Three)

Your request: You may Appeal to Expedited External Independent Medical Review only after you have appealed through Level Two. You have four months after you receive Aetna's Level Two decision to send Aetna your written

request for Expedited External Independent Medical Review. Your request should include any additional information to support your request for the service. Your written request for Expedited External Independent Medical Review should be sent to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll-free number)
Fax:	860-975-1526

You and your treating **provider** are not responsible for the cost of any Expedited External Independent Medical Review.

Process

There are 2 types of Expedited External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition. The expedited external independent reviewer is a Provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be a Provider who typically manages the condition under review.

   Within 1 business day of receiving your request, Aetna must:

   - Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna's decision; and the relevant portions of Aetna utilization review guidelines. Aetna must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier appeal levels.

   Within 2 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent reviewer organization (the "IRO").

   Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

   Within 48 hours of receiving the IRO's decision, the Director of Insurance must mail a notice of the decision to Aetna, you, and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the expedited external independent reviewer.

   Within 1 business day of receiving your request, Aetna must:

   - Mail a written acknowledgement of your request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review, your Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 2 business days of receiving this information, the Director of Insurance must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, you, and your treating Provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Director of Insurance. The Director of Insurance will have 48 hours after receiving the IRO's decision to send the decision to Aetna, you, and your treating Provider.

Decision

Medical Necessity Decision: If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Decision: If you disagree with the Director of Insurance's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for Appeals from Expedited External Independent Medical Review Appeals decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

External, Independent Review (Level Three)
Your request: You may obtain External Independent Medical Review only after you have sought any Appeals through standard and expedited Level One and Level Two. You have four months after receipt of written notice from Aetna that your Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. You must send a written request for External Independent Medical Review and any material justification or documentation to support your request for the covered service or claim for a covered service to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll-free number)
Fax:	860-975-1526

Neither you nor your treating Provider is responsible for the cost of any External Independent Medical Review.

Process

There are 2 types of External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition. The external independent reviewer is a Provider retained by an outside Independent Review Organization ("IRO") that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

   Within 6 business days of receiving your or the Director of Insurance's request, or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna's utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

Within 5 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent review organization (the "IRO").

Within 45 calendar days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, you, and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the external independent reviewer.

   Within 6 business days of receiving your request or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement of your request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review, your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, you, and your treating Provider.

   The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward your case to an IRO. The IRO will have 45 calendar days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, you, and your treating Provider.

Decision

Medical Necessity decision: If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna's decision to deny the service, the Appeal is over. Your only further option is to pursue your claim in Superior Court. However, on written request by the IRO, you or Aetna, the Director of Insurance may extend the 45-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage decision: If you disagree with the Director of Insurance's final decision on a contract coverage issue, the Member may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Arkansas ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Arkansas. **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 Arkansas, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Important Information

In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
1123 South University Avenue
Little Rock, AR 72204
(501) 686-2945

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01 AR)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;

- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Handicapped Dependent Children *(GR-9N-31-015-01)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

At the request and expense of Aetna, proof that your child is fully handicapped must be submitted to Aetna by your Employer. In no event will this requirement preclude any eligible dependent, regardless of age. If such incapacity or dependency is removed or terminated, your Employer shall notify **Aetna**.

Continuation of Coverage for Your Former Spouse

If health coverage for the your dependent spouse would terminate due to divorce or annulment, the former spouse may continue to be covered (except for Dental Insurance). Your former spouse must have been covered for the health coverage as your dependent for at least 3 months in a row.

The person has to request continuation within 10 days of the date of the divorce or annulment.

Premium payments must be continued. Coverage will end on the earlier of the following:

- The end of 120 days after the date of the divorce or annulment.
- The date you are no longer covered under this Plan.
- The date the person becomes eligible for like coverage, including coverage for any preexisting condition, under any other group plan.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The end of the period for which contributions have been made.

Continuing Coverage after Termination of Employment

If your coverage terminates for any reason you may continue any health coverage (except Dental Insurance) in force for you and your dependents but, only if the coverage has been in force for you for at least 3 months in a row.

You have to make request in writing for this continuation. It must be done within 10 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 120 day period which starts on the date coverage would otherwise end.
- The date you are eligible for like coverage, including coverage for any preexisting condition under any other group plan.
- The date you fail to make the required contributions.
- The date health coverage discontinues as to employees of your former Employer.

Coverage for a dependent will end when the dependent:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the group contract.

In no event will the covered amount for In-Network charges exceed more than 25% of the covered amount for Out-of-Network charges.

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

Outpatient In Vitro Fertilization Expenses
Covered Expenses for outpatient in vitro fertilization procedures will be paid when they are incurred by:

- A female employee; or
- The dependent legal spouse of a male employee.

Also included are expenses incurred for cryopreservation. They will be paid on the same basis as for **illness**; but only if all these tests are met:

- The procedures are performed while the person is not confined in a **hospital** or any other facility as an inpatient.
- Her oocytes are fertilized with her husband's sperm.
- She and her husband have a history of **infertility**. It must have lasted at least 2 years; or the **infertility** is associated with one or more of these conditions:
  - Endometriosis.
  - Exposure in utero to diethylstilbestrol; known as DES.
  - Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy.
  - Abnormal male factors contributing to the **infertility**.
- She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- The in vitro fertilization procedures are performed:
  - at a medical facility licensed or certified by the Arkansas Department of Health; or certified by the Arkansas Department of Health as either.
  - meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
  - meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

Not more than the **In Vitro Fertilization Maximum** will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization or treatment from an **out-of-network provider** will not be covered. You will be responsible for full payment of the service.

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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Infertility Treatment *(GR-9N-S-10-055-01)*			
Outpatient In Vitro Fertilization	Deductibles and or Copays are the same as required for any other illness. The Coinsurance is the same that is payable for any other illness.	Deductibles and or Copays are the same as required for any other illness. The Coinsurance is the same that is payable for any other illness.	Deductibles and or Copays are the same as required for any other illness. The Coinsurance is the same that is payable for any other illness.
Maximum Benefit per lifetime:	$15,000	$15,000	$15,000

Preventive Health Care Services Expenses

The charges below are included as Covered Expenses even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 19 years of age:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Developmental and behavioral assessment.
- Vision and hearing screening.
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth;
  - Urinalysis, tuberculin test, blood tests such as hematocrit and hemoglobin tests;
  - Tests for phenylketonuria, hypothyroidism, galactosemia, sickle-cell anemia, and other genetic disorders of metabolism.
- Immunizations for infectious disease.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will only include charges incurred for Preventive Health Care Services performed at birth and at approximately each of the following ages:

2 weeks	18 months	10 years
2 months	2 years	12 years
4 months	3 years	14 years
6 months	4 years	16 years
9 months	5 years	18 years
12 months	6 years	
15 months	8 years	

Expenses incurred for vaccines and immunizations for infectious disease will not be subject to a Calendar Year deductible; per visit copay/deductible; coinsurance; or maximum benefit per Calendar Year.

Not covered are charges incurred:

- For services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- For services which are for diagnosis or treatment of a suspected or identified injury or disease;
- for services not performed by a physician or under his or her direct supervision;
- For medicines, drugs, appliances, equipment or supplies;
- For dental exams;

- For exams related in any way to employment;
- For pre-marital exams; or
- To the extent they are in excess of the Medicaid reimbursement level in the State of Arkansas for the same service or supply.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.
- If you are confined in a hospital, the date you are discharged from the hospital.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 60 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 60 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 60 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 60 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Corrective Surgery and Treatment of Craniofacial Anomaly

Covered expenses include charges made for corrective surgery and related medical care including dental, vision and the use of at least one hearing aid for insured's of any age diagnosed as having craniofacial anomaly.

Corrective surgery means the use of surgery to alter the form and function of the cranial tissues due to a congenital or acquired musculoskeletal disorder. Craniofacial anomaly means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.

Denial or any limitation of coverage based on lack of medical necessity to improve a functional impairment would be referred for an external review under Arkansas External Review regulation.

The expenses will be payable in accordance with the service rendered and location of where the expense was incurred.

Medical Foods and Low Protein Modified Foods *(GR-9N 11-156 01-AR)*

Covered expenses include charges incurred by a covered person; for non-prescription enteral formulas for which a physician has issued a written order; and are for the treatment of malabsorption caused by:

Crohn's Disease;
ulcerative colitis;
gastroesophageal reflux;
gastrointestinal motility;
chronic intestinal pseudoobstruction; and
inherited diseases of amino acids and organic acids.

Covered Expenses for inherited diseases of: amino acids; and organic acids; will also include food products modified to be low protein.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	California ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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.

(GR-9N 08-020 01 CA)

YOUR BOOKLET-CERTIFICATE CONTAINS IMPORTANT INFORMATION REGARDING NETWORK AND OUT-OF-NETWORK HEALTH CARE. PLEASE READ THIS INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Obtaining Coverage for Dependents *(GR-9N 29-010 01 CA) (GR-9N 29-010-01 CA)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer as outlined in the *Coverage for Domestic Partners* section following; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N 29-010 01 CA)(GR-9N 29-010-01 CA)*

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under California law for entering into a domestic partnership; and
- are "domestic partners" as determined in accordance with rules set by your Employer.

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.

Anesthesia and Associated Hospitalization For Certain Dental Care *(GR-9N 11-181 01 CA)*

Covered expenses include charges made for general anesthesia and associated **hospital**, surgery center or other licensed facility charges in connection with dental care if any of the following applies:

- the person is a child age 6 or under;
- the person has a medical condition that requires hospitalization or general anesthesia for dental care; or
- the person is disabled.

As used in this section, "disabled" means a person, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

- It is attributable to a mental or physical impairment or combination of mental and physical impairments.
- It is likely to continue.
- It results in substantial functional limitations in one or more of the following activities:
  - self-care;
  - receptive and expressive language;
  - learning;
  - mobility;
  - capacity for independent living; or
  - economic self-sufficiency.

Aetna may require prior authorization for covered services and associated charges in the same manner that prior authorization is required for these benefits in connection with other covered medical care.
Charges in connection with the dental procedure itself, including, but not limited to, those for the professional fees of the dentist are not covered.

Mark T. Bertolini
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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Colorado ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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-11-155-05 CO)*

These are services, provided as part of an active individualized family service plan that enhances 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.

Coverage for early intervention services for covered children supplements, and does not duplicate or replace treatment for autism spectrum disorders.

Coverage for Early Intervention services is available to an eligible child from birth up to the child's third birthday. The services are available up to the maximum annual benefit limit as set by the Division of Insurance, Department of Regulatory Agencies and the State of Colorado. The services must be performed by a qualified early intervention service provider listed in the applicable registry. Contact the Colorado Department of Human Services, Division of Community and Family Support Health Department for eligibility requirements and benefit limits.

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

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	$6,516	$6,516	$6,516

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.

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 health 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 health 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

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-34-025-09 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 are insufficient 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 U.S. Food and Drug Administration (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. 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 age 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 singe 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 internally 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.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Connecticut ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Connecticut. **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 Connecticut, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Pregnancy Related Expenses *(GR 9N 11-100 01 CT)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

Covered expenses include charges for pregnancy and childbirth expenses at the same level of any other applicable illness or injury. For inpatient care of the mother and newborn child, the plan will pay for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

Any decision to shorten such minimum coverages shall be made by the attending physician**;** in consultation with the mother. In such cases; covered services shall include: home visits; parent education; and assistance and training in breast or bottle-feeding.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Understanding Precertification *(GR-9N 08-060-01-CT)*

Precertification

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits will be reduced by $500 or 50% of the cost of the expense whichever is less, or the plan may not pay any of the expenses if the service or supply is not medically necessary. The list of services requiring **precertification** follows on the next page.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency** outpatient **medical condition**:	You or your **physician** should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an **emergency admission**:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.

For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.
For prenatal care and delivery:	As soon as possible after the attending **physician** confirms pregnancy and again within 48 hours of the birth or as soon thereafter as possible. No benefit reduction will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Amendment included with this Booklet-Certificate.

How Failure to Precertify Affects Your Benefits *(GR-9N 08-070-01-CT)*
A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered. If your treatment is not **precertified** by you or your **provider**, the benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- The benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

Subrogation and Right of Reimbursement

The sub-section entitled "Subrogation and Right of Reimbursement", if included in the General Provisions part of your Booklet-Certificate, has been removed and does not apply to your plan of benefits.

Coordination of Benefits
Getting Started - Important Terms

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

Allowable Expense means a health care service or expense, 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. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

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 reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific 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 of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. 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.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or **recognized charges** and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

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.

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.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, 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 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.

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 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.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Delaware ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Delaware. **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 Delaware, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Scalp Hair Prosthesis *(GR-9N-11-110-01 DE)*

Coverage is provided for expenses for scalp hair prostheses worn for hair loss resulting from alopecia areata, resulting from an autoimmune disease. Coverage is subject to the same limitations and guidelines as other prostheses.

Autism Spectrum Disorders

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including behavioral therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan; and

- The covered child is diagnosed with Autism Spectrum Disorder with onset prior to age twenty-one; and
- The **covered expenses** are incurred prior to attainment of age twenty-one.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative
- Asperger's Syndrome; and
- Pervasive Developmental Disorder - Not Otherwise Specified.

Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered

Retail Pharmacy Benefits *(GR-9N-13-005-01 DE)*

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits *(GR-9N-13-005-01 DE)*

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Copays/Deductibles *(GR-9N S-26-011 01) (GR-9N S-26-013 01) (GR-9N S-26-016 01)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	**NETWORK**	**OUT-OF-NETWORK**
Preferred Generic Prescription Drugs		
For each 30 day supply	$20	$20
For more than a 30 day supply but less than a 61 day supply	$40	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$30	$30
For more than a 30 day supply but less than a 61 day supply	$60	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply	$20	$20
For more than a 30 day supply but less than a 61 day supply	$40	Not Applicable

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$50	$50
For more than a 30 day supply but less than a 61 day supply	$100	Not Applicable

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	District of Columbia ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 District of Columbia. **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 District of Columbia, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Preventive Health Care Services Expenses *(GR-9N 11-005-01 WV)*

Even though the charges are not incurred in connection with treatment of an **illness** or **injury**, the plan will pay for the preventive health care services listed below for **physicians** and laboratory services. Children who are residents of the District of Columbia, wards of the District and have special needs shall be covered for benefits until age 21. All other dependent children are covered from birth through age 17.

Preventive Health Care Services

These are services provided for a routine physical exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision Screening;
- Hearing screening, including a newborn hearing screening before discharged from the hospital, by an audiologists, otolaryngologists, or other qualified person, which shall include at least one of the following tests:
  - Auditory brain stem response;
  - Otoacustic emissions; or
  - Other appropriate nationally recognized, objective physiological screening tests.
- Appropriate Immunizations;
- Anticipatory guidance;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth;
  - Urinalysis, tuberculin test, and blood test such as hematocrit and hemoglobin tests, and tests to screen for sickle hemoglobinopathy.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam; and
- **Necessary** care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity.

Covered expenses will only include charges incurred for:

- An exam performed at birth;
- All exams performed during the first 12 years of the child's life;
- 3 exams performed during each year of life thereafter up to age 21, as defined by the District of Columbia above; otherwise through age 17.

This preventive health services benefit does *not* cover:

- Diagnosis or treatment of **injury** or **illness** (whether suspected or identified);
- Exams given during your stay in a **hospital** or other facility, excepts are provided above;
- Medicines, drugs, appliances, equipment or supplies, except as provided above;
- Dental exams;
- Exams related in any way to employment; or
- Pre-marital exams.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Preventive Health Services Care	xxxx exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.

Emergency Department HIV Screening *(GR-9N 11-035 02 DC)*

Coverage is provided for the cost of voluntary HIV screening tests performed while receiving emergency medical services, other then HIV screening, in a hospital emergency room.

- Coverage is provided for one annual HIV screening performed in a hospital emergency room.

- Coverage is provided to reimburse the costs of administering such a test, all laboratory expenses to analyze the test, and the costs of communicating to the patient the results of the test and any applicable follow-up instructions for obtaining health care and supportive services; and

- This coverage shall not be subject to any annual or coinsurance deductible or any co-payment other than the co-payment that the insured would have to pay for the applicable hospital emergency department visit.

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

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

- A baseline mammogram;
- An annual mammogram screening;
- 1 cervical cytological screening every -12 months;
- 1 gynecological exam every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

Mammograms and cervical cytologic screenings are not subject to the calendar year deductible, if applicable.

The plan pays for the charges for colorectal cancer screening and laboratory testing you incur:

- if you are age 50 and over; or
- any age if you are considered to be at high risk for colorectal cancer; and
- When prescribed by a physician.

Colorectal cancer screening and laboratory testing includes:

- One fecal occult blood test (FOBT) every 12 months;
- One flexible sigmoidoscopy every 5 years;
- One double contrast barium enema every 5 years;
- One colonoscopy every 10 years.

High risk for colorectal cancer means a covered person has:

- A family history of familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast; ovarian, endometrial or colon cancer or polyps; or
- Chronic inflammatory bowel disease; or
- A background, ethnicity or lifestyle that the physician believes puts the covered person at the elevated risk for colorectal cancer.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N S-10-015 02)*			
Routine Mammography	100% per test No Calendar Year **deductible** applies.	60% per test No Calendar Year **deductible** applies.	80% per test No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Cervical Cytologic Screenings	100% per test No Calendar Year **deductible** applies.	60% per test No Calendar Year **deductible** applies.	100% per test No Calendar Year **deductible** applies.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01 DC)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;

- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Outpatient Treatment Of Mental Disorders			
Outpatient Services	$40 per visit **copay** after Calendar Year **deductible** then the plan pays 100% for the first 40 visits, 100% for each visit thereafter	60% per visit after the Calendar Year **deductible** for the first 40 visits, 60% for each visit thereafter	80% per visit after the Calendar Year **deductible** for the first 40 visits, 80% for each visit thereafter
Outpatient Treatment of Substance Abuse			
Outpatient Services	$40 per visit **copay** then the plan pays 100% for the first 40 visits, 100% for each visit thereafter	60% per visit after Calendar Year **deductible** for the first 40 visits, 60% for each visit thereafter	80% per visit after Calendar Year **deductible** for the first 40 visits, 80% for each visit thereafter

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Florida ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Florida. **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 Florida, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(GR-9N-29-010-06 FL)
An eligible dependent child includes:

- Your biological children.
- Your stepchildren.
- Your legally adopted children.
- Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court-order.
- Your grandchildren in your court-ordered custody.
- Any child whose parent is your child and your child is covered as a dependent under this Plan.
- Any other child with whom you have a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

How and When to Enroll *(GR-9N 29-015 05 FL)*

Initial Enrollment in the Plan
You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within 60 days from birth.

Routine Physical Exams

Covered expenses include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children for child health supervision services from birth through age 16 also include:

- An initial **hospital** check up; and
- Well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians. Included are:
  - A review and written record of the child's complete medical history.
  - Physical Examination.
  - Developmental and behavioral assessment.
  - Anticipatory Guidance.
  - Appropriate Immunization.
  - Laboratory Test.

Unless specified above, not covered under this benefit are charges 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**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Well Child Exams Includes coverage for immunizations.	Refer to the Schedule of Benefits for details on the exam copay (if applicable) and coinsurance. No Calendar Year **deductible** applies.	Refer to the Schedule of Benefits for details on the coinsurance and deductible. No Calendar Year **deductible** applies.	Refer to the Schedule of Benefits for details on the coinsurance and deductible. No Calendar Year **deductible** applies.
Child Immunizations Only	Refer to the Schedule of Benefits for details on the exam copay (if applicable) and coinsurance. No Calendar Year **deductible** applies.	Refer to the Schedule of Benefits for details on the coinsurance and deductible. No Calendar Year **deductible** applies.	Refer to the Schedule of Benefits for details on the coinsurance and deductible. No Calendar Year **deductible** applies.

Routine Mammograms

Covered expenses include charges incurred for routine mammograms as follows:

Routine Mammogram for women

Autism Spectrum Disorders

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment, (including Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan; and

- The covered child is diagnosed with Autism Spectrum Disorder with onset prior to age eight; and
- The **covered expenses** are incurred prior to attainment of age eighteen or eighteen and older if the covered child is in high school.

Applied Behavioral Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Autism Spectrum Disorder *(GR-9N S-10-061-02-FL)*			
	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

Pregnancy Related Expenses *(GR-9N S- 11-100 01 FL)*

Covered expenses include charges made by a **physician**, nurse midwives and midwives for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Cleft Lip or Palate Treatment *(GR-9N-11-155-01 FL)*

(Dependent Children Under Age 18 only)
Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;

- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

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

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

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

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar year when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Extension of Benefits

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

In the case of maternity expense coverage, coverage will continue to be available to you for medical expenses directly relating to a pregnancy that began before coverage under this Policy ceased. Such benefits will be covered only for the period of that pregnancy.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

Aetna Life Insurance Company

Hartford, Connecticut 06156

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

Policyholder:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Georgia ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Georgia. **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 Georgia, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Ongoing Specialist Care: *(GR-9N-S-08-035 01 GA)*

If you have a condition which requires ongoing care from a **specialist**, you or your **physician** may request a standing **referral** to such **specialist**. Circumstances which may warrant this type of **referral** include, but are not limited to, a high risk pregnancy or dialysis treatment. You should initially make this **request** through your **PCP**. If **Aetna**, the **PCP** and/or **specialist**, in consultation with a medical director, determine that such a standing **referral** is appropriate, **Aetna** will authorize such a **referral** to a network **specialist**. **Aetna** is not required to permit you to elect to have an out-of-network **specialist**, unless such a **specialist** is not available within the network. Any authorized **referral** shall be made pursuant to a treatment plan approved by **Aetna** in consultation with the **PCP**, the **specialist** and you, or your designee.

The treatment plan may limit the number of visits or the period during which the visits are authorized and may require the **specialist** to provide the **PCP** with regular updates on the specialty care provided, as well as all necessary medical information.

When You Don't Need a PCP Referral

You don't need a **PCP** referral for:

- **Emergency care** – See *Coverage for Emergency Medical Conditions.*
- **Urgent care** – See *Coverage for Urgent Conditions.*
- **Out-of-Network Benefits** – the plan gives you the option to visit health care providers and facilities that are not in the provider network without a **referral** for **covered expenses**. You may also visit **network providers** without a **referral**. You will receive out-of-network coverage for these **covered expenses**.

- **Direct access services** – services from **network providers** for which the referral is not required. Certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the *What the Plan Covers* and *the Schedule of Benefits* sections. Refer to the *What the Plan Covers* section for information on when these benefits are covered. You can directly access these network specialists for:
  - Routine gynecologist visits;
  - Annual screening mammogram for age-eligible women;
  - Routine eye exams in accordance with the schedule.
  - Dermatology care.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

In no event will the covered amount for In-Network charges exceed more than 30% of the covered amount for Out-of-Network charges. When In-Network office visits are paid at 100% after a dollar copay, the GA Office of Insurance equates this to a 90% coinsurance when figuring the Out-of-Network coinsurance allowance. In no event will any benefit be paid at a coinsurance less than 60%.

Accessing Pharmacies and Benefits *(GR-9N-S-125-015 01 GA)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. These **network pharmacies** have contracted with **Aetna** to provide **prescription drugs** and other supplies to you at a **negotiated charge**. You also have the choice to access state licensed **pharmacies** outside the **network** for **covered expenses**.

Obtaining your benefits through **network pharmacies** has many advantages. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you

To better understand the choices that you have with your plan, please carefully review the following information.

Pharmacy Benefit Limitations *(GR-9N 13-015 01 GA)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

Copays/Deductibles *(GR-9N S-26-011 01) (GR-9N S-26-013 01) (GR-9N S-26-016 01)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	$20	$20
For all fills of at least a 31 day supply and up to a 90 day supply filled at a **mail order pharmacy**	$40	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$30	$30
For more than a 30 day supply but less than a 91 day supply (mail order)	$60	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$20	$20
For more than a 30 day supply but less than a 91 day supply (mail order)	$40	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	$50	$50
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	$100	Not Applicable

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	100% of the **negotiated charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

The sub-section titled 'Subrogation', if included in the 'General Provisions' section of your Booklet-Certificate, has been removed and does not apply to your plan.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Hawaii ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Hawaii. **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 Hawaii, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Telehealth Expenses Services *(GR-9N-11-195-01 HI)*

Covered expenses include charges made by a **physician** or other health provider for medical services in connection with telehealth services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided.

Telehealth means the use of telecommunications services, as defined in 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, does not constitute a telehealth service for the purpose of this coverage.

A **physician**-patient relationship must exist between the covered person and one of the health care providers involved in the telehealth interaction for the service to be covered.

In the event that a **physician**-patient relationship does not exist between the covered person and the health care provider to be involved in the telehealth interaction, a telehealth mechanism may be used to establish a **physician**-patient relationship.

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

Outpatient In Vitro Fertilization Expenses

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred:

- by a female employee; or
- by the dependent wife of a male employee;

For outpatient in vitro fertilization procedures. They will be included on the same basis as for disease; but only if all these tests are met:

- The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
- Her oocytes are fertilized with her husband's sperm.
- She and her husband have a history of infertility. It must have lasted at least 5 years; or the infertility is associated with one or more of these conditions:
  1. Endometriosis.
  2. Exposure in utero to diethylstilbestrol; known as DES.
  3. Blockage of, or surgical removal of, one or both fallopian tubes; known as lateral or bilateral salpingectomy.
  4. Abnormal male factors contributing to the infertility.
- She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- The in vitro fertilization procedures are performed at a medical facility that meets:
  - the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
  - the American Society for Reproductive Medicine's minimum standards for programs of in vitro fertilization.

Benefits will be provided to the same extent as any other covered expense under the plan. Not more than one course of treatment will be covered in the person's lifetime.

Child Health Supervision Services *(GR-9N-11-005-01 HI)*

Covered expenses include charges by a **physician** or under the supervision of a **physician** for visits made for child health supervision services for a child from birth to age 5 for up to 12 visits at these intervals: birth; 2 month; 4 month; 6 month; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; and 5 years.

Child health supervision services for each visit include: a history, physical examination, developmental assessment, anticipatory guidance, immunization, and laboratory tests, in keeping with prevailing medical standards.

Prevailing medical standards for the purpose of these services means the recommendations of the Immunizations Practices Advisory Committee of the U.S. Department of Health and Human Services and the American Academy of Pediatrics.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Child Health Supervision Services	100% per visit	60% per visit	80% per visit
Immunizations	100% per visit No Calendar Year **deductible** applies.	60% per visit No Calendar Year **deductible** applies.	80% per visit No Calendar Year **deductible** applies.

The Preexisting Conditions Exclusions and Limitations section, if included in your Booklet-Certificate, does not apply to your plan of benefits and is hereby removed.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

You may also cover as your dependent.

A reciprocal beneficiary.

You must file a notarized "Declaration of Reciprocal Beneficiary Relationship" with the Director of Health of the State of Hawaii. The Director will register the Declaration and send you a Certificate of Reciprocal Beneficiary Relationship.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Illinois ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Illinois. **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 Illinois, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(GR-9N 02-005-01 IL)

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the Group Policy's fee schedule, or recognized charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Group Policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE GROUP POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill covered persons for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the covered person other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free number on your ID card.

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

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

- A baseline mammogram for women age 35 through age 39;
- A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under age 40 with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors;
- An annual mammogram for women age 40 and older;
- Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a **physician**;
- An annual Pap smear;
- An annual digital rectal examination and a prostate specific antigen (PSA) test for asymptomatic men age 40 and older;

- Colorectal cancer screening, examinations, and laboratory tests incurred by a covered person age 50 and over; or of any age who is considered to be at high risk for colorectal cancer; and when prescribed by a **physician**;
- Colorectal cancer screening, examinations, and laboratory testing includes:
  - One fecal occult blood test (FOBT) every 12 months;
  - One FOBT every 12 months plus one flexible sigmoidoscopy every 5 years;
  - One digital rectal exam every 12 months;
  - One double contrast barium enema every 5 years;
  - One colonoscopy every 10 years;
  - Other approved screenings, examinations, and laboratory tests prescribed by a **physician**;
- High risk for colorectal cancer means a covered person has:
  - A personal or family history of familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial; or colon cancer or polyps;
  - Chronic inflammatory bowel disease; or
  - A background, ethnicity or lifestyle that the **physician** believes puts the covered person at elevated risk of colorectal cancer;
- Surveillance tests for ovarian cancer for women that:
  - Have a family history of at least one first-degree relative with ovarian cancer; clusters of women relatives; or nonpolyposis colorectal cancer; or
  - Test positive for BRCA1 or BRCA2 mutations;
- Surveillance tests for ovarian cancer is defined as: annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and a pelvic exam.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Mammography Baseline for covered females age 35-39. Under age 40 with breast cancer history or other risk factors when considered Medically Necessary by covered female's health care provider and for covered females age 40 and over.	100% per test No Calendar Year **deductible** applies.	60% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies.

HPV Expense Benefit *(GR 9N S 11-20 03 IL)*

The plan pays for charges made by a **physician** for administering the human papillomavirus coverage for a human papillomavirus vaccine (HPV) that is approved for marketing by the Federal Food and Drug Administration.

Coverage is payable at the same level as any other physician expense.

Eosinophilic Gastrointestinal Disorder Expense *(GR-9N-11-005-01 IL)*

Covered expenses included charges for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing **physician** has issued a written order stating that the amino acid-based elemental formula is medically necessary.

Continuing Coverage for Dependents After Your Death *(GR-9N 31-015-01 IL)*

If you should die while enrolled in this plan, your dependent's health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Additional Dependent Coverage Provision

If you should die while enrolled in this plan, your dependent child's coverage will be continued if your dependent child has reached the limiting age under the coverage or is not eligible for coverage under the spousal continuation privilege in this *Continuation of Coverage* section, upon the earliest to happen of the following:

- Failure to pay premiums when due, including any grace period;
- When coverage would terminate under the terms of the existing policy if your dependent child was still your eligible dependent;
- The date on which your dependent child first becomes, after the date of election, an insured employee under any other group health plan; or
- The expiration of 2 years from the date continuation coverage began.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Continuation of Coverage For Your Former Spouse & Retired Employee's Spouse (Spousal Continuation Privilege)

If Health Expense Coverage for your dependent spouse would terminate due to dissolution of marriage, your death or retirement, your former spouse and covered dependents may continue to be covered. For purposes of this section, the term "former spouse" includes a widow or a widower, as well as a divorced spouse. It does not include a retired employee's spouse. Your former spouse or retired employee's spouse has to apply for continuation coverage and pay the initial monthly premium within 30 days of the date your former spouse or retired employee's spouse receives the notice of the right to continue, or the right to continuation of coverage is forfeited and the continuation of benefits terminated.

Premium payments must be continued. Coverage for a former spouse under age 55 will not continue beyond the first to occur of:

- The date the former spouse becomes covered for like coverage under any group policy.
- The end of a 2 year period after the date of dissolution of marriage.
- The date coverage would have terminated if the marriage had not been dissolved. This will not apply during the first 120 days following dissolution of marriage or employee spouse's death unless the coverage would be terminated due to a change in the group contract during such 120 days.

- The date dependent coverage ceases under this Plan for your Eligible Class.
- The date the former spouse remarries.
- The end of the period for which contributions have been made.

Coverage for a former spouse and a retired employee's spouse age 55 or older will not continue beyond the first to occur of:

- The date the former spouse becomes covered for like coverage under any group policy.
- The date coverage would have terminated, except due to the retirement of an employee, if the marriage had not been dissolved. This will not apply during the first 120 days following dissolution of marriage, or employee spouse's death or retirement unless the coverage would be terminated due to a change in the group contract during such 120 days.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The date the former spouse remarries.
- The end of the period for which contributions have been made.
- The date that person reaches the qualifying age or otherwise establishes Medicare eligibility.

Upon the termination of continuation coverage, the former spouse will be entitled to convert the coverage to an individual health insurance policy.

Continuation rights granted to former spouses will include eligible covered dependents covered prior to the dissolution of marriage or the death of the employee, or the retirement of the employee for a former spouse who has attained age 55.

Payment of Benefits *(GR-9N 32-025-01 IL)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. For all health coverages, benefits will be paid within 30 days following receipt of written proof to support the claim.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Indiana ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Indiana. **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 Indiana, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Notice to Policyholders and Certificate Holders

Questions regarding your policy or coverage should be directed to:

Aetna Life Insurance Company
Contact Number: See your Member ID Card.

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

Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

Routine Cancer Screenings

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

- 1 baseline mammogram for covered females who are age 35 but less than age 40, or one mammogram every 12 months for covered females less than age 40 who are at risk;
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;

- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are **covered expenses** if you are age 50 and older, or less than age 50 and at high risk 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.

Diabetic Equipment, Supplies and Education *(GR-9N-11-135-01 IN)*

`**Covered expenses** include charges for the following services, supplies, equipment, as ordered by a **physician**, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Iowa ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Iowa. **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 Iowa, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Special Enrollment Periods

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Maine ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Maine. **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 Maine, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Cancer Screenings

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

- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months or as recommended by a physician;
- 1 gynecological exam every 12 months including a rectovaginal pelvic exam for women age 25 and over who are at risk for ovarian cancer;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 50 to 72.
- colorectal cancer screening for asymptomatic individuals who are: 50 years of age or older; or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. Colorectal cancer screening means a colorectal cancer examination and laboratory test (colonoscopy) recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N-S-10-015-01)*			
Routine Mammography For covered females age 40 and over. (Coverage for Routine Mammography will be provided the same as any other Diagnostic X-Rays.)	100% per test No Calendar Year **deductible** applies.	60% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies.
Prostate Specific Antigen Test For covered males age 50 to 72.	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.
Routine Digital Rectal Exam For covered males age 50 to 72.	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.
Routine Pap Smears (as required by a physician)	100% per test No Calendar Year **deductible** applies.	60% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies.

Hospice Care *(GR 9N 11 070 ME)*

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 a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. 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; and
- Consultation or case management services by a **physician**;
- Medical supplies and DME.

- Pain and symptom management;
- Nutritional counseling; and
- Counseling; Bereavement Services; and
- Respite Care

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** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies and DME;
  - **Pain and symptom management;**
  - Counseling;
  - Nutritional counseling.
  - Bereavement Services; and
  - Respite care

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- 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; maintenance of the house.

Important Reminders
Refer to the *Schedule of Benefits* for details about any applicable **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**.

Other Covered Health Care Expenses *(GR-9N 11-080ME*

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician or a licensed acupuncturist**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Prosthetic Devices *(GR 9N 11 110 ME)*

Covered expenses include charges made for prosthetic devices. A prosthetic device is an artificial device meant to replace, in whole or in part, an arm or a leg.

Prosthetic devices are payable at no less than on the same basis as the most current standards of Medicare. The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of an arm or a leg lost or impaired as a result of disease or injury or congenital defects. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The plan will not cover expenses and charges for, or expenses related to:

- a prosthetic device that contains a microprocessor; or
- a prosthetic device that is designed exclusively for athletic purposes; or
- prosthetic services rendered by a provider who does not contract with Aetna and prosthetic devices provided by a vendor that is not designated by Aetna.

Prosthetic devices need to be precertified by Aetna. Refer to *How the Plan Works* for details about **precertification**.

Prosthetic Devices other than artificial devices meant to replace, in whole or in part, an arm or a leg.

In addition, **covered expenses** include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee, or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the Exclusions section.

Autism Spectrum Disorders *(GR-9N 11-171-01 ME)*

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Coverage for Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the *Schedule of Benefits*.

Hearing Aid Expenses *(GR-9N 11-110-020 ME)*

Covered expenses include charges for the purchase of a hearing aid for each hearing-impaired ear for an individual who is under 19 years of age.

Hearing aid means a non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

The hearing loss must be documented by a physician or audiologist licensed pursuant to Maine Title 32, chapter 77. The hearing aid must be purchased from an audiologist licensed pursuant to Maine Title 32, chapter 77 or a licensed hearing aid dealer licensed pursuant to Maine Title 32, Chapter 23-A.

Limitations:

- No benefits will be payable for a charge which is for batteries, cords and other assistive listening devices, including, but not limited to, frequency modulation systems.
- The maximum benefit payable is limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months.

Hearing Aid Expenses *(GR-9N-S-10-080-01)*	80% per visit after Calendar Year **deductible** For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.	60% per visit after Calendar Year **deductible** For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.	80% per visit after Calendar Year **deductible** For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.

Diabetic Equipment, Supplies and Education *(GR-9N S- 11-135-ME)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training and education services that are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control project within the Bureau of Health.
- Foot care to minimize the risk of infection.

Metabolic Formula and Special Modified Low-Protein Food Products *(GR-9N S- 11-135-ME)*

Coverage shall include metabolic formula and special low-protein food products that have been prescribed by a licensed **Physician** to treat an inborn error of metabolism. An inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. A special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

Physician Services*(GR-9N-S-11-020-01)*

Physician Visits

Covered 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** include those for telemedicine services. Coverage shall not be denied on the basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the **covered person** and a health care provider. Coverage is provided for only those services that are **medically necessary**, subject to the terms and conditions of this plan for covered health care services provided through in-person consultation. "Telemedicine", as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. "Telemedicine" does not include the use of audio-only telephone or facsimile machine or e-mail. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Amino Acid-Based Elemental Infant Formula *(GR-9N S- 11-137-ME)*

This Plan pays charges for amino acid-based elemental infant formula for children 2 years of age and under, regardless of the method of delivery of the formula, when a licensed **physician** has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined under Maine law, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed **physician** may be required to confirm and document ongoing **medical necessity** at least annually. **Covered expenses** will be payable the same as any other medical expense.

Such documentation includes when a licensed **physician** has diagnosed and the through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic, fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula

Metabolic Formula	80% per prescription or refill after Calendar Year **deductible**	60% per prescription or refill after Calendar Year **deductible**	80% per prescription or refill after Calendar Year **deductible**

Medical Plan Exclusions *(GR 9N 28 025 ME)*

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under What *The Plan Covers* section or by amendment attached to this Booklet-Certificate.

Drugs, medications and supplies:
- Any services related to the dispensing, injection or application of a drug, except services related to contraception;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;

Food items: Any food item, including but not limited to infant formulas, nutritional supplements, vitamins, including but not limited to **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of

nutrition. This exclusion does not apply to Metabolic Formula and Special Modified Low Protein Food Products as specifically provided in the *What the Plan Covers* section.

When Coverage Ends for Employees *(GR-9N 30-005 01 ME)*

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
- Your employment stops. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, your coverage may continue until stopped by your employer as described below:
  - If you are not at work due to disease or **injury**, your employment may be continued until stopped by your employer, but not beyond 30 months from the start of the absence.
  - If you are not at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Continuing Coverage

If you:

- terminate employment due to a temporary lay-off; or
- lose employment due to an **injury** or disease that you claim to be compensable under workers' compensation;

You may continue any Health Expense Coverage (except Comprehensive Dental Expense Coverage) then in force if:

- you have been employed by your employer for at least 6 months;
- you are not eligible for Medicare;
- you are not covered for like benefits;
- you are not eligible for like benefits under any group plan;
- you are not eligible for continuation of like benefits because of any state or federal law; and
- premium payments are continued.

The coverage may be continued for you or any of your dependents who have been covered as your dependent for at least 3 months or for you and any such dependents. If a dependent has not been eligible for 3 months, the dependent must have been covered at all times while eligible.

You have to make request in writing for this continuation. This must be done within 31 days of the date coverage would otherwise cease. The request must include an agreement to pay up to 102% of the applicable group rate.

Coverage will cease on the first to occur of:

- The date you are eligible for coverage under any other group plan.
- The date you fail to make the contributions needed.
- The date the Workers' Compensation Commission determines that the disease or **injury,** that entitled the person to continued coverage, is not compensable.
- The end of a one year period which starts on the date coverage would otherwise cease.

Coverage of a dependent will cease earlier when the dependent ceases to be a defined dependent.

If any coverage being continued ceases because it has been continued for one year, the person may apply for a personal policy in accordance with the Conversion Privilege. If it ceases for any other reason, the Conversion Privilege is not available.

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people;
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
  - Medical supplies and DME;
  - Nutritional counseling;
  - Counseling; and
  - Bereavement Services.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.

- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-GrpAppealsER-03)*

Policyholder:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Maine Appeals Procedure and External Review
Issue Date:	January 19, 2016
Effective Date:	This Booklet-Certificate Amendment is effective on January 1, 2016

The group policy noted above has been amended. The following summarizes the changes in the group policy and the Booklet-Certificate, describing the policy terms, is amended accordingly. This amendment is effective on the date shown above.

The following Appeals Procedure, Exhaustion of Process and External Review provisions replace the same provisions appearing in your Booklet-Certificate or any amendment or rider issued to you:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including Plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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 course of treatment that was previously approved.

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

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Retrospective Claim: Any claim that is not a "Pre-Service Claim."

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

- seriously jeopardize your life or health;
- 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.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 48 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 48 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 to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision for non-urgent services after the claim is made as soon as possible, but not later than 2 working days after obtaining all necessary information. **Aetna** will not later render an adverse decision with respect to any pre-authorized services except if fraudulent or materially incorrect information was provided at the time the services were pre-authorized, and such information was used in pre-authorizing the service.

Retrospective Claims

Aetna will notify you of a **retrospective** claim decision after the claim is made as soon as possible, but not later than 30 calendar days after obtaining all necessary information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision within one working day after obtaining all necessary information.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment within one working day after obtaining all necessary information.

As to medical and **prescription drug** claims only, if you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

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 Member Services. The complaint 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 written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional 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 or two levels of **appeal** depending upon the type of coverage provided under the Plan. As to medical and **prescription drug** claims only, a **final adverse benefit determination** notice will also provide an option to request an **External Review**.

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

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

Send your written **appeal** to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the telephone number listed on the notice.

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

As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal – Adverse Benefit Determination (Group Health Claims)

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**. Except for Urgent Care Claims, an acknowledgement letter will be sent to you within three (3) working days of Aetna's receipt of the appeal. The letter will contain the name; address; and telephone number of the Appeal Coordinator assigned to review the appeal. If the appeal concerns medical necessity; appropriateness; health care setting; level of care; or effectiveness the Coordinator will be a clinical peer health care professional. If the letter requests additional information, it must be sent to Aetna within the next 15 days.

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

Pre-Service Claims
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal** or receipt of any additional information requested.

Concurrent Care Claim Reduction or Termination
Aetna shall issue a decision within one working day of the request for an **appeal** or receipt of any additional information requested.

Retrospective Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal** or receipt of any additional information requested. **Aetna** will notify you in writing within 5 working days after making the determination.

If Aetna's final decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the review;
- A statement of the Committee's understanding of the **Appeal**; and all pertinent facts;
- The specific plan provisions upon which the decision is based;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials;
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau;
- A description of the process to obtain a level two Appeal (including the rights; procedures; and time frames that govern such an **appeal**).
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
- Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process;
- Any other information required pursuant to the federal Affordable Care Act.

Level Two Appeal - Adverse Benefit Determination (Group Health Claims)

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative has the right to file a level two appeal. The appeal must be submitted following the receipt of notice of a level one Appeal.

A level two Appeal of an decision involving an Urgent Care Claim, or a claim involving medical necessity; appropriateness; health care setting; level of care; or effectiveness; shall be provided by the Aetna Appeals Committee. The majority of the Committee will be made up of persons not previously involved in the Appeal. However, a person who was previously involved in the Appeal may be a member of the Committee. Such person may also appear before the Committee to present information or answer questions. The Committee must include one or more clinical peer health care professionals who were not previously involved in the Appeal, who are not a subordinate of a person involved in the Appeal, and who have no financial or other personal interest in the outcome of the review. The level two Appeal decision must have the concurrence of the majority of such clinical peer health care professionals.

For a level two Appeal concerning all other appeals, the majority of the Committee will be made up of employees or representatives of **Aetna** who were not previously involved with the Appeal. However, a person who was previously involved in the Appeal may be a member of the Committee. The person may also appear before the Committee to present information; or answer questions.

If you ask to appear in person before the Committee, the Committee will notify you in writing 15 days in advance of the hearing date. The notice will also advise you if an attorney will be present to argue **Aetna's** case against you. **Aetna** will also advise you of your right to obtain legal representation. The hearing will be held during regular business hours. If you cannot attend the hearing, you may participate by conference call; or other available technology; at **Aetna'**s expense. You may also request that **Aetna** consider a postponement and rescheduling of the hearing. In addition:

- You may request **Aetna** to provide you with all relevant information that is not confidential or privileged.
- You may be helped or represented at the hearing by the person of your choice.
- You may submit supporting material. This may be done both before and during the hearing.
- You may ask questions of any Aetna representative.

Urgent Care Claims
Aetna shall issue a decision within 36 hours of receipt of the request for a level two Appeal.

Pre-Service Claims
Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two Appeal.

Concurrent Care Claim Reduction or Termination
Aetna shall issue a decision within one working day of the request for an **appeal** or receipt of any additional information requested.

Retrospective Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two Appeal.

If the decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the level one Appeal review;
- A statement of the Committee's understanding of the Appeal and all pertinent facts;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials; and
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau.

Aetna will keep the records of your complaint for 3 years.

NOTICE:

You may contact the Maine Bureau of Insurance at any time during the Appeal Process outlined above. The address is:

Maine Bureau of Insurance
Consumer Health Care Division
34 State House Station
Augusta, Maine 04333
Telephone Number: 1-800-300-5000
Web: www.state.me.us/pfr/ins/ins_index.htm

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you can establish any:

litigation;

arbitration; or

administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
As to medical and **prescription drug** claims only, if **Aetna** does not adhere to all **adverse benefit determination** and **appeal** requirements (including required timeframes for issuing decisions) of the State of Maine and of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna.**

External Review

If Aetna renders a decision resulting in an Adverse Benefit Determination you may contact the Maine Bureau of Insurance to request an external review; if you or your provider disagrees with Aetna's decision. An external review is a review by an independent external review organization, who has expertise in the problem or question involved. The Maine Bureau of Insurance oversees the external review process. It also contracts with approved independent review organizations to carry out the external review and render a decision.

To request an **External Review**, any of the following requirements must be met:

You have received notice of the denial of a claim by an Adverse Benefit Determination from Aetna; and
Your claim was denied because Aetna determined that the care was not **medically necessary** or was **experimental or investigational**; and
The cost of the service or treatment in question for which you are responsible exceeds $500; and
You have exhausted the applicable internal **appeal** processes.

The **adverse benefit determination** you receive from **Aetna** will describe:

- the external review process and the procedure to follow if you wish to pursue an external review;
- your right to get assistance from **Aetna** to request the external review;
- your right to attend the external review; submit; and obtain supporting material relating to the adverse decision; ask questions of any **Aetna** representative; and have outside assistance; and
- your right to seek assistance from; or file a complaint with; the Maine Bureau of Insurance (including the Bureau's address and toll-free number).

You or your authorized representative must send the request for external review in writing to the Maine Bureau of Insurance. The request must be made within 12 months of the date you received the final adverse decision letter from Aetna. You also must include: a copy of the final adverse decision letter; and all other pertinent information that supports your request. You will not be required to pay any fees.

Expedited request for external review: You will not be required to exhaust the applicable internal Appeals process before requesting an external review if:

- **Aetna** has failed to make a decision within the required time period; or
- You and **Aetna** agree to bypass the internal Appeals procedure; or
- Your life or health is in serious jeopardy; or
- You have died.

The Maine Bureau of Insurance will contact the external review organization that will conduct the review of your claim. The external review organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external review organization will consider how appropriate the service is based on:

- All relevant clinical information relating to your physical and mental condition;
- Any concerns you have voiced about your health status; and
- All relevant clinical standards, including but not limited to, those standards and guidelines used by Aetna.

You will be notified of the decision of the external review organization within 30 calendar days of receipt of your request form and all necessary information from the Maine Bureau of Insurance. If your condition is such that a delay would put in serious jeopardy your life or health or your ability to regain maximum function, a decision will be made no later than 72 hours after receipt of the request.

Aetna will abide by the decision of the External Review Organization.Aetna is responsible for paying the Maine Bureau of Insurance for the cost of the external review.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.

Mark T. Bertolini
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Appeals - Medical
Issue Date: January 19, 2016

Aetna Life Insurance Company

Hartford, Connecticut 06156

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

Policyholder:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Maryland ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Maryland. **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 Maryland, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition.

A physician is not you or related to you.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

This notice is sent to give you information about your benefits for mental health and substance use disorder services. Under both Massachusetts laws and federal laws, benefits for mental health services and substance use disorder services must be comparable to benefits for medical/surgical services. This means that copays, coinsurance and deductibles, for mental health and substance use disorder services must be at the same level as those for medical/surgical services. Also, our review and authorization of mental health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

If we make a decision to deny or reduce authorization of a service, we will send you a letter explaining the reason for the denial or reduction. We will send you or your provider a copy of the criteria used to make this decision, at your request.

If you think that we is are not handling your benefits for mental health and substance use disorder services in the same way as for medical/surgical services, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint using the DOI's Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI's webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint by phone by calling 877-563-4467 or 617-521-7794.
If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal under your plan. You must also file an appeal with us in order to have a denial or reduction in coverage of a service reviewed. This may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. Follow the appeal procedures outlined in your plan for more information about filing an appeal.

Aetna Life Insurance Company

Hartford, Connecticut 06156

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

Policyholder:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Massachusetts ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Massachusetts. **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 Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician Profiling

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

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French
Services d'interprétation et de traduction
Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ຜແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຢູ່ທີ່ປາກົດເທິງບັດປະຈຳ ໂອສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະ ລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ແຜນກບໍລິການລູກຄ້າບອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິງສຽງບໍ່ຄ່ອຍໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

ៈសេវាកម្មផ្តែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់ អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្តែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្តែកសេវាកម្មនៃអតិថិជនរបស់ Aetna មានមធ្យោបាយរកសេវាកម្មបកប្រែ តាមរយៈខ្សែទូរស័ព្ទភាសា AT&T ។ លេខ TDD# សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。Aetna的專業用戶服務人員使用AT&T語言專線 (AT&T Language Line) 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的TDD號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتا للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإداريا فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريم خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

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

(GR-9N 29-010-01)
An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

When You Receive a Qualified Child Support Order *(GR-9N 29-015-01 MA)*
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, **Aetna** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Prosthetic Devices *(GR-9N 11-110-01 MA)*

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for you;
- A scalp hair prosthesis (wig) for hair loss due to treatment of any form of cancer or leukemia;
- Therapeutic/molded shoes and shoe inserts required for the treatment of or to prevent complications of diabetes.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

PPO Medical Plan *(GR-9N S10-80-01 MA)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prosthetic Devices	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.
Any coinsurance requirement for artificial limb devices to replace, in whole or in part, an arm or leg will not exceed 20%, unless such coinsurance applies to all covered benefits. With respect to Out of Network charges, any coinsurance will not exceed 40% of the cost unless such coinsurance applies to all covered benefits under the plan.		
Scalp Hair Prosthesis for Cancer or Leukemia Patients *(GR-9N-S10-95-01 MA)*	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.
Maximum Benefit per Calendar Year	$350	$350

Cleft Lip or Palate Treatment

Treatment of Cleft Lip or Palate of Dependent Children Under Age 18

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Medical, dental, oral surgery and facial surgery, surgical management including pre- and post-operative care provided by oral and plastic surgeons;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Preventative and restorative dentistry to ensure good health;

- Adequate dental structures for orthodontic treatment or prosthetic management therapy;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiology;
- Nutrition services;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

If such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered under this section.

Limitations
Unless specified above, not covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Hearing Aids Expense

Covered expenses include charges incurred by a covered person for the cost of one hearing aid per hearing impaired ear every 36 months upon written statement from the covered person's treating physician that the hearing aid(s) are necessary regardless of etiology.

Covered expenses also include related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds.

Coverage is provided under the same terms and conditions as for any other condition.

Hearing Aids *(GR-9N-S-10-80-05 MA)*	80% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**

Clinical Trial Expenses *(GR-9N 11-210-01 MA)*
This Plan will pay for **medically necessary** and routine patient care, **physician**, and facility charges you incur when enrolled in a qualified clinical trial study.

A "qualified clinical trial" means a patient research study that meets the following criteria:

- it must be intended to treat cancer; and
- it must be peer reviewed and approved by one of the following:
  - one of the United States Institutes of Health;
  - a center or cooperative group of the National Institutes of Health;
  - a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
  - the Food and Drug Administration (FDA) pursuant to an investigational new drug exemption;
  - the Department of Defense;
  - the Department of Veterans Affairs; or
- with respect to a Phase II, III and IV clinical trial
  - a qualified institutional review board; and
  - it must be provided by a provider of health care which has the experience and training to provide the treatment in a capable manner; and
- with respect to Phase I clinical trials
  - it must be provided by an academic medical center or affiliated facility, and the providers conducting the trial shall have staff privileges at the academic medical center; and
  - you meet the patient selection criteria for participation in the qualified clinical trial; and
  - you must have signed, prior to participation in the qualified clinical trial, a statement of consent.
- available clinical or pre-clinical data provide a reasonable expectation that participation is likely to be beneficial to you; and
- it does not duplicate existing studies; and
- it must have a therapeutic intent and must assess the effect of the intervention.

Charges for **covered expenses** you incur for the treatment provided in the clinical trial are payable on the same basis as any disease or illness covered under this plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Clinical trial expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to: precertification and referral requirements.

Not covered under this plan are:

- any drug or device that is approved by the FDA, even when the off-label use of the drug or device has not been approved by the FDA for that indication, if the drug or device is paid for by the manufacturer, distributor, or provider of the drug or device; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research; and
- any expenses related to participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or

- Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.

For Massachusetts residents, to the extent required by law, this also includes the following licensed providers:

- Psychologist;
- Independent Clinical Social Worker;
- Mental Health Counselor;
- Nurse Mental Health Clinical Specialist; and
- Marriage and Family Therapist.

Telemedicine *(GR-9N-S-11-020-01)*

Covered expenses include the application of telemedicine for covered services provided by a **physician** acting within the scope of their license as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. Coverage is provided for only those services that are **medically necessary** and subject to the terms and conditions of the covered person's policy. Coverage for health care services under this provision will be consistent with coverage for health care services provided through an in-person consultation.

Telemedicine means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or e-mail.

Aetna may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by **Aetna**.

The deductible, copayment or coinsurance will not exceed any deductible, copayment or coinsurance applicable to an in-person consultation.

Treatment of Speech, Hearing and Language Disorders *(GR-9N 11-145-01 MA)*

The plan will pay for the diagnosis and treatment by individuals licensed as speech-language pathologists or audiologists for acute speech, hearing and language disorders, but only if the services are made for:

- Diagnostic services rendered to find out if, and to what extent, your ability to speak or hear is lost or impaired;
- Rehabilitative services rendered that are expected to restore or improve your ability to speak or hear.

The treatment of speech, hearing and language disorders benefit does ***not*** cover:

- Diagnostic or rehabilitative services rendered before you become eligible for coverage or after termination of coverage;
- Special education (including lessons in sign language) to instruct you if your ability to speak or hear is lost or impaired, to function without that ability.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries;
- Hearing exams required as a condition of employment;
- Diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - that any school system, by law, must provide; or
  - as to speech therapy, to the extent such coverage is already provided for under Early Intervention Services and Home Health Care Services; or
- Any services unless they are provided in accordance with a specific treatment plan which:
  - details the treatment to be rendered and the frequency and duration of the treatment;
  - provides for ongoing services; and
  - is renewed only if such treatment is still necessary.

Early Intervention Services Expenses *(GR9N 11 020 03 MA)*

Covered expenses include early intervention services provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the **Physician** for dependents from birth until thirty six (36) months of age.

Early Intervention	No **copay, coinsurance** or **deductible** applies.	No **copay, coinsurance** or **deductible** applies.

Autism Spectrum Disorders *(GR-9N 11-171 02 MA)*

Covered expenses include charges the following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**:

- **Habilitative or Rehabilitative Care**;
- **Pharmacy Care**;
- **Psychiatric Care**;
- **Psychological Care**; and
- **Therapeutic Care**.

Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; including:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorders--Not Otherwise Specified

Coverage for the diagnosis and treatment of Autism Spectrum Disorders is payable same as any other **illness** or **injury**.

Coverage for the diagnosis and treatment of autism spectrum disorders is not subject to a limit on the number of visits an individual may make to an autism services provider.

Any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of Autism Spectrum Disorders cannot be less than those imposed on coverage for the diagnosis and treatment of physical conditions.

Common Terms

Autism Services Provider: a person, entity or group that provides treatment of autism spectrum disorders.

Autism Spectrum Disorders
Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Board Certified Behavior Analyst

A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Habilitative or Rehabilitative Care

Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.

Pharmacy Care

Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.

Psychiatric Care

Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care

Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care

Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

Preventive Health Care Services *(GR-9N 11-225-01 MA)*

The plan covers preventive health care services even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 6 years of age.

Preventive health care services are services provided for a routine exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision and hearing screening, including a newborn hearing screening test performed before the child is discharged from the **hospital** or **birthing center**;
- Lead poisoning screening;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth; and
  - Urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease; and
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered expenses will only include charges for preventive health care services performed at birth and at approximately each of the following ages:

2 months	18 months
4 months	2 years
6 months	3 years
9 months	4 years

12 months 5 years
15 months

Not covered under this benefit are charges incurred for:

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

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

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

- 1 baseline mammogram, for covered females age 35 but less than 40;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months.

Treatment of Infertility *(GR-9N 11-135 02 MA)*

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

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.

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**, has been recognized and diagnosed as **infertility**, by a gynecologist, infertility specialist, or your **physician**, 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.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of one (1) year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits

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; and
- intrauterine insemination.

Advanced Reproductive Technology (ART) Benefits

Advanced Reproductive Technology is defined as:

- in vitro fertilization (IVF-EP);
- zygote intrafallopian transfer (ZIFT);
- gamete intra-fallopian transfer (GIFT);
- cryopreserved embryo transfers;
- intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services are defined as: ART services, products, and procedures that are **covered expenses** under this *Booklet-Certificate*.

Infertility Case Management is defined as a program administered by **Aetna** that consists of:

- evaluation of medical records to determine whether ART services are **medically necessary**;
- determination of whether ART services are covered benefits;
- pre-authorization for ART services by an ART Specialist when ART services are **medically necessary** and are covered benefits; and
- case management for the provision of ART services for an eligible covered person.

Eligibility for ART Benefits

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

- You must have been unable to achieve a successful pregnancy through less invasive, medically appropriate treatment.
- Be referred by your **physician** to **Aetna's** infertility case management unit;
- Be issued pre-authorization for ART services by **Aetna's** infertility case management unit to an ART specialist.
- ART services are available only from the ART specialists for whom you have been issued a pre-authorization by **Aetna's** infertility case management unit. Treatment received without pre-authorization will not be covered and you will be responsible for payment of all services..

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*:

- IVF-EP; GIFT; ZIFT; or cryopreserved embryo transfers;
- ICSI or ovum microsurgery;
- payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF-EP program, including fertilization and culture; and
- charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and bank of sperm or inseminated eggs, for ART, to the extent such costs are not covered by the donor's insurer, if any.

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, prior to enrolling in the infertility program, 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);
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35;
- Reversal of sterilization surgery;
- 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. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;
- 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 or related to the treatment of **infertility** that are not **medically necessary**;
- If you have Prescription Drug Coverage that includes oral and self-injectable infertility drugs, then oral and self-injectable infertility drugs are excluded under your medical plan. If you do not have Prescription Drug Coverage for oral and self-injectable infertility drugs then they are covered same as any other prescription under your medical plan;
- Any services or supplies provided without pre-authorization from **Aetna's** infertility case management unit;
- **Infertility** and ART Services that do not meet the Medical Necessity guidelines, for example, women who are deemed to be in natural menopause versus women in premature ovarian failure which would be subject to medical review;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;
- Services and supplies obtained without pre-authorization from Aetna's infertility case management unit.

Coverage under this benefit will terminate immediately upon termination of coverage under this *Booklet-Certificate*, subject to group continuation coverage requirements under COBRA or state continuation laws.

Important Note
Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment *(GR-9N S10-55-01 MA)*		
Basic and Comprehensive Infertility Expenses	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.
Advanced Reproductive Technology (ART) Expenses	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.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135 02 MA)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin and Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets, including blood glucose monitoring strips, ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training;
- Foot care to minimize the risk of infection;
- All lab tests and urinary profiles;
- Voice synthesizers and visual magnifying aids;
- Therapeutic/molded shoes and shoe inserts;
- Insulin pump supplies;
- Insulin pens; and
- Oral medications.

Physician Visits *(GR-9N 11-020-01 MA)*

Covered expenses also include:

- Diabetic Self-Management Education: Training designed to instruct a person in self-management of diabetes. It may also include training in self care or diet. Such charges must be made by:
  - a **physician**, nurse practitioner, clinical nurse specialist; or
  - a **pharmacy** or dietician who is legally qualified by the *Commonwealth of Massachusetts* to provide diabetic management education.
- Your diabetic equipment and self-management education services benefit does *not* cover:
  - a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
  - a general program not just for diabetics; or
  - a program made up of services not generally accepted as necessary for the management of diabetes.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.

Prescription Drug *(GR-9N 34-080-01 MA)*

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- Drugs and medicines prescribed for the treatment of cancer or HIV/AIDS even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of such indication is in one of the standard reference compendia or in medical literature. The term "standard reference compendia" means the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term "medical literature" means published scientific studies appearing in any peer-reviewed national professional journal.

Hormone Replacement Therapy *(GR-9N 11-200-01 MA)*

The plan will pay for outpatient services and supplies related to your hormone replacement therapy for peri and post menopausal women on the same basis as any other **illness**.

Contraception Services *(GR-9N 11-005-01 MA)*

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.

Pregnancy Related Expenses *(GR-9N 11-100-01 MA)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit be conducted by a registered nurse, **physician**, or certified nurse midwife; and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Treatment of Mental Disorders and Substance Abuse *(GR-9N 11-172 01 MA)*

Treatment of Mental and Nervous Disorders *(GR-9N 11-172-04 MA)*

Covered expenses include chargers made for the inpatient and outpatient treatment of **Biologically-Based Mental Disorders** and **Non-Biologically Based Mental Disorders** by **Behavioral Health Providers** under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. This includes the same copayments, coinsurance or deductibles.

Benefits consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment to take place in the least restrictive clinically appropriate setting.

In addition to the above, **covered expenses** also include charges made for:

- Rape Related Mental or Emotional Disorders - Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if the **covered person** is a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive that coverage provided for any other type of health care for physical illness.

- Children and Adolescents under the age of 19 - Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for any other health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

  (1) an inability to attend school as a result of such a disorder;
  (2) the need to hospitalize the child or adolescent as a result of such a disorder;
  (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

  Coverage shall be continue to be provided to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

- Psychopharmacological Services/Neuropsychological Assessment Services - Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

DEFINITIONS:
BIOLOGICALLY BASED MENTAL DISORDERS
(1)schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; 10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism.

OUTPATIENT SERVICES

- a licensed hospital,
- a mental health or substance abuse clinic licensed by the department of public health,
- a public community mental health center,
- a professional office, or home-based services.

INTERMEDIATE SERVICES

- Acute and other residential treatment
- Clinically managed detoxification services
- Crisis stabilization
- Day treatment
- Level III community-based detoxification,
- In-home therapy services
- Intensive Outpatient Programs (IOP)
- Partial hospitalization

INPATIENT SERVICES

may be provided in

- a general hospital licensed to provide such services,
- in a facility under the direction and supervision of the department of mental health
- private mental hospitals licensed by the department of mental health, and substance abuse facilities licensed by the department of public health.

LICENSED MENTAL HEALTH PROFESSIONAL

- a licensed physician who specializes in the practice of psychiatry,
- a licensed psychologist,
- a licensed independent clinical social worker,
- a licensed mental health counselor,
- a licensed nurse mental health clinical specialist or
- a licensed marriage and family therapist within the lawful scope of practice for such therapist.

Substance Abuse*(GR-9N 11-172-03 MA)*

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers.** 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;** and
- 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**.

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles,** maximums, **coinsurance limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital** as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Important Reminder
Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Intermediate Care Treatment
Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute residential treatment, partial confinement treatment, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.

Outpatient Treatment
Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital**, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital, or in a substance abuse facility. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums, **coinsurance limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Behavioral Health Provider *(GR-9N 34-010-01 MA)*
A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorders** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists;
- Substance abuse facility licensed by the department of mental health;
- Level III community-based detoxification; acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health;
- Mental health or substance abuse clinic licensed by the department of public health;
- A public community mental health center;
- Professional office or home-based services;
- Licensed independent clinical social worker;
- Licensed mental health counselor;
- Licensed nurse mental health clinical specialist; or
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Mental Disorder *(GR-9N 34-065 04 MA)*

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist, a psychiatric social worker, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.
- Paranoia and other psychotic disorders.
- Delirium and dementia.
- Affective disorders.
- Eating disorders.
- Post traumatic stress disorders.
- Substance Abuse.
- All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Also included is any other mental condition which requires **Medically Necessary** treatment.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Mental Disorders and Substance Abuse *(GR-9N S-10 062 01 MA)*		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Outpatient Services	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible applies.**	60% per visit after the Calendar Year **deductible**

Thirty-One Day Continuation *(GR-9N 31-015-01 MA)*

Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to **Aetna** within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

Continuation of Coverage for Your Former Spouse

If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

Continuation of Coverage: Employment Ceases

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.
- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

Continuation of Coverage: Plant Closing

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

Continuation of Coverage for Your Dependents After Your Death

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent's coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.

Continuation of Coverage for Your Child

The terms of this Continuation of Coverage apply only to your dependent child:

- who attains the limiting age for eligibility; and
- whose coverage under this Plan would otherwise terminate; and
- who is engaged in an ongoing treatment under this Plan, in accordance with a written treatment plan, for a mental, behavioral, or emotional disorder.

Such child's health expenses coverage, except dental expense coverage, may be continued, if:

- written request for such continuation is made within 31 days of the date coverage terminates; and
- that such request includes the following:
  - an agreement to pay up to 100% of the cost to the plan; and
  - evidence, satisfactory to **Aetna,** of the existence of such a mental, behavioral, or emotional disorder.

Premium payments must be made.

Coverage will cease on the first to occur of:

- the end of a 36 month period that starts on the date coverage would otherwise terminate (but not before the date a course of treatment for a non-biological mental disorder for children or adolescents under the age of 19, as specified in the treatment plan, is completed); or
- the date the child fails to provide the required proof that the course of treatment is still ongoing; or
- the date the child is eligible for similar benefits under any group plan; or
- the date the child becomes eligible for other coverage under the Group Policy; or
- the date the child fails to make any required contributions; or
- the date health expense coverage under this Plan discontinues for employees of your employer.

Aetna will have the right to require proof of the continuation of the course of treatment. **Aetna** also has the right to examine your child as often as needed while the course of treatment continues at its own expense. An exam will not be required more often than once each year.

If any coverage being continued ceases, the child may apply for a personal policy in accordance with the Conversion Privilege.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Michigan ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Michigan. **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 Michigan, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Any elective abortion coverage that may be provided by the plan has been removed from the Certificate of Coverage, unless the procedure is necessary to preserve the life of the mother.

Autism Spectrum Disorders

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis (including the autism diagnostic observation schedule or any other standardized diagnostic measure for autism spectrum disorders that is approved by the Michigan Insurance Commissioner) and treatment, (including behavioral therapy, pharmacy care, therapeutic care, psychiatric care, psychological care and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician** or **behavioral health provider** (psychologist) as part of a Treatment Plan; and the **covered expenses** are incurred prior to attainment of age nineteen.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association:

- Autistic Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder - Not Otherwise Specified.

Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Missouri ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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.

Any elective abortion coverage that may be provided by the plan has been removed from the Certificate of Coverage, unless the procedure is necessary to preserve the life of the mother.

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 benefit 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.

Partial Confinement Treatment for Alcoholism and Substance Abuse

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**.

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

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.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Early Intervention Services	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Child Early Intervention Services *(GR-9N-S-10-010-01)*

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

Anesthesia and Hospital Charges For Dental Care *(GR-9N 11-186 01 MO)*

Covered expenses include charges incurred by a covered person for the administration of general anesthesia and hospital charges for dental care only to the following covered persons:

- a child under the age of 5;
- a person who is severely disabled; or
- a person who has a medical or behavioral condition which required hospitalization or general anesthesia when dental care is provided.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment GR-9N-CR1-Autism-ABA 01

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP-861472

Effective Date: January 1, 2016

The group policy specified above has been amended. The following summarizes the changes in the Group Policy, and the Booklet-Certificate describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

The following **Autism Spectrum Disorder** provisions have been added to your Booklet-Certificate. These provisions apply unless their effect is to provide a lesser benefit or coverage than that already provided in the Booklet-Certificate.

1. The following schedule component is added to your Booklet-Certificate.

PLAN FEATURES	NETWORK	OUT OF NETWORK
Applied Behavioral Analysis *for individuals younger than 19 years of age*	Unlimited	Unlimited

2. The following benefit provision is added to your Booklet-Certificate.

Autism Spectrum Disorders

Covered expenses include charges made by a **Physician**, **Behavioral Health** or **Autism Spectrum Disorders provider** for the services and supplies for the diagnosis and treatment of **Autism Spectrum Disorder** when ordered by a **physician** or a licensed psychologist as part of a Treatment Plan; and

- The individual is diagnosed with **Autism Spectrum Disorder;**
- The **covered expenses** are incurred for individuals younger than 19 years of age.

Treatment for **Autism Spectrum Disorders**, care prescribed or ordered for an individual diagnosed with an **Autism Spectrum Disorder** by a licensed physician or licensed psychologist, including, equipment **medically necessary** for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

- Psychiatric care;
- Psychological care;
- Habilitative or rehabilitative care, including applied behavior analysis therapy;
- Therapeutic care;
- Pharmacy care.

The treatment plan(s) for **Applied Behavior Analysis** must include the following:

- a diagnosis;
- proposed treatment, by type , frequency, and duration;
- the anticipated outcomes stated as goals; and
- the frequency by which the treatment plan will be updated.

Regarding **Applied Behavior Analysis, Aetna** may request additional information. **Aetna** may require the submission of an updated treatment plan not more than once every six months unless **Aetna** and the treating **physician** agree to more frequent updates. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual being treated for an **Applied Behavior Analysis** and shall not apply to all individuals being treated for **Applied Behavior Analysis** by a **physician** or psychologist. **Aetna** is responsible for the cost of obtaining any review or treatment plan.

Benefits are payable on the same basis as any other physical illness.

Limits on the number of visits to a **physician** or other service provider do not apply.

3. The following limitations language replaces the current language now appearing under the Short-Term Rehabilitation benefit in your Booklet-Certificate.

Unless specifically covered above, not covered under this benefit are charges for:

- Therapies for the treatment of delays in development unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. However this exclusion will not apply to newborn children with respect to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Also this exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of **Autism Spectrum Disorders.**
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer.
- Any services unless provided in accordance with a specific treatment plan.
- Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect.
- Services provided during a stay in a **hospital, skilled nursing facility,** or **hospice facility,** except as stated above.
- Services provided by a **home health care agency**.
- Services not performed by a physician or under the direct supervision of a physician.
- Services provided by a physician or physical, occupational or speech therapist 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.
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

4. The General Exclusions Section of the Booklet-Certificate has been amended as follows:

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs. This exclusion does not apply to charges incurred for the diagnosis and **necessary** treatment of **Autism Spectrum Disorders**.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Communication disorders and behavioral disorders regardless of the underlying cause. This exclusion does not apply to charges incurred for the diagnosis and **necessary** treatment of Pervasive Developmental Disorders and **Autism Spectrum Disorders;** and

- Services, treatment, and educational testing and training related to behavioral (conduct) problems. This exclusion does not apply to charges incurred for the diagnosis and necessary treatment of Pervasive Developmental Disorders.

Therapies for the treatment of delays in development unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. However this exclusion will not apply to newborn children with respect to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Also this exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of **Autism Spectrum Disorders.**

5. The Glossary section of the Booklet-Certificate is hereby amended to add the following definition(s):

Autism Spectrum Disorders.

This means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Applied Behavior Analysis

This means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

Autism Spectrum Disorder Provider

This means any person, entity, or group that provides diagnostic or treatment services for **Autism Spectrum Disorders** who is licensed or certified by the state of Missouri or any person who is licensed under chapter 337 as a board certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board certified behavior analyst.

Diagnosis of Autism Spectrum Disorders

This means **medically necessary** assessments, evaluations, or tests in order to diagnose whether an individual has an **Autism Spectrum Disorder.**

Habilitative or Rehabilitative Care

This means professional, counseling, and guidance services and treatment programs, including **Applied Behavior Analysis** that are necessary to develop the functioning of an individual.

Health Benefit Plan

This means a policy, contract, certificate or agreement entered into, offered or issued by **Aetna** to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Line Therapist

This means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

Pharmacy Care

This means medications used to address symptoms of an **Autism Spectrum Disorder** prescribed by a licensed physician, and any health-related services deemed **medically necessary** to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.

Psychiatric Care

This means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care

This means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care

This means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Amendment: MO Autism-ABA 01 Network Plans (MHP)
Issue Date: January 19, 2016

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment: GR9NCR1TELEHEALTH V001

Policyholder: University of Pennsylvania Postdoctoral Insurance Plan

Group Policy No.: GP- 861472

Effective Date: **January 1, 2016**
or

The date you become covered under the Policy.

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

The following is added to the Other Covered Health Care Expenses section of your Booklet-Certificate:

Telehealth

Covered expenses include the application of telehealth for covered services provided by a **physician** acting within the scope of their license as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. Coverage is provided for only those services, including diagnosis, consultation and treatment that are **Medically Necessary** and subject to the terms and conditions under your plan. Coverage for health care services under this provision will be consistent with coverage for health care services provided through an in-person consultation.

Telehealth means the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient. Site-origination fees for the telehealth provider, however, are not covered.

Aetna may limit coverage of telehealth services to those health care providers that are in a network approved by **Aetna**.

The deductible or copayment will not exceed any deductible or copayment applicable to an in-person consultation.

Refer to the Primary Care Physician or Specialist benefit in your Schedule of Benefits for the applicable copayment/coinsurance.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.

Mark T. Bertolini
Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Amendment: Telehealth
Issue Date: January 19, 2016

Aetna Life Insurance Company

Hartford, Connecticut 06156

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

Policyholder:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	New Jersey ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 New Jersey. **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 New Jersey, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents *(GR-9N 29-010 03 NJ)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/**civil union partner**; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Civil Union Partner *(GR-9N 34-015 02 NJ)*

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	New Mexico ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 New Mexico. **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 New Mexico, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Immunization Expenses

- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Immunizations for human papillomavirus (HPV) and the materials for administration of immunizations for covered females age 9 up to age 27; and
- Testing for Tuberculosis.

Anesthesia and Hospital Charges for Dental Surgery

Covered expenses include charges for **hospital** services and general anesthesia may by a **hospital** or **surgical center** for dental surgery for the following:

- Covered persons exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to product superior results;
- Covered persons for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
- Dependent children who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
- Covered persons with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- Other procedures for which **hospital** confinement or general anesthesia in a **hospital** or **surgical center** is **medically necessary**.

Routine Cancer Screenings

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

- 1baseline mammogram for covered females age 35 through 39;
- 1 mammogram every 2 years for covered females age 40 through 49;
- 1 mammogram every 12 months for covered females age 50 and over;
- cytologic screening, as recommended by your physician in accordance with national medical standards for covered females age 18 and over. Cytologic screening means a pap test and a pelvic exam for asymptomatic as well as systematic females;
- 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
- 1 human papillomavirus (HPV) screening exam every 3 years for covered females age 30 and over;

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

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 (FDA);
- 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 this Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Children's Hearing Aid

Covered expenses for your covered dependent children include charges for one hearing aid for each hearing-impaired ear during any 36 consecutive month period. **Covered expenses** also include charges for fitting and dispensing services and molds necessary to maintain optimal fit.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Visual reading urine and ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;

- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Foot care to minimize the risk of infection; and
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; which shall be limited to:
  - **medically necessary** visits upon the diagnosis of diabetes;
  - visits following a **physician** diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and
  - visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and
  - Medical nutrition therapy related to diabetes management.

Covered expenses include new or improved equipment, appliances, **prescription drugs** for the treatment of diabetes, insulin or supplies for the treatment of diabetes when approved by the food and drug administration.

Treatment of Jaw Joint Disorder

This Plan covers charges made by a **physician, hospital** or **surgery center** for the diagnosis; and surgical and non-surgical treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	New York ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 New York. **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 New York, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Payment of Benefits *(GR-9N 32-025 01 NY)*

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than: (a) 30 days of receipt of a claim transmitted electronically or via the internet; or (b) 45 days for a claim submitted by other means. Written proof must be provided for all benefits.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Ohio ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Ohio. **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 Ohio, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 28 years of age.

Child Health Supervision Services *(GR-9N 11-005-01 OH)*

Covered expenses include charges for the periodic review of a child's physical and emotional status performed by a **physician** for a child from birth to age 9.

A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Anticipatory guidance.
- Development and behavioral assessment.
- Hearing screening.
- Vision and lead toxicity screening and immunizations.
- One series of hereditary and metabolic tests performed at birth.
- Urinalysis and blood tests such as hematocrit and hemoglobin tests.
- Counseling and guidance of the child and the child's parents or guardians on the results of the physical exam.

Child Health Supervision Services are limited to charges incurred at birth and approximately each of the following ages:

One month	12 months	4 years
2 months	15 months	5 years
4 months	18 months	6 years

6 months	2 years	7 years
9 months	3 years	8 years

Child Health Supervision Services provided from birth to age 1 including hearing screening are covered up to the Birth to Age One Maximum.

Child Health Supervision Services thereafter are covered up to the Age One to Age Nine Calendar Year Maximum.

Hearing screenings are covered up to the Hearing Screening Maximum.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for Child Health Supervision Services.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Child Health Supervision Services (From Birth to Age 9)	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Child Health Supervision Services			
Birth to Age One Maximum	$500	$500	$500
Birth to Age One Hearing Screening Maximum	$75	$75	$75
Age One to Age Nine Calendar Year Maximum	$150	$150	$150

Screening Mammography and Cytologic Screening *(GR-9N 11-005-01 OH)*

Covered expenses include charges for screening mammography to detect the presence of breast cancer in adult women and cytologic screening for the presence of cervical cancer.

Mammography screenings are covered up to:

- 1 screening for a woman age 35 but under age 40;
- 1 screening every 2 years for a woman age 40 but under age 50 or 1 every year if a physician has determined that the woman has risk factors to breast cancer;
- 1 screening every year for a woman age 50 or older but under age 65.

Cytologic screenings are covered up to every 12 month consecutive period.

The most that the plan will pay for each mammography screening is the Mammography Screening Maximum.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N S-10-15 01 OH)*			
Routine Mammography	100% per test No Calendar Year **deductible** applies.	60% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies
Maximum visits	▪ 1 visit for a mammogram for females age 35 through 39 ▪ 1 visit every year for females age 40 and over	▪ 1 visit for a mammogram for females age 35 through 39 ▪ 1 visit every year for females age 40 and over	▪ 1 visit for a mammogram for females age 35 through 39 ▪ 1 visit every year for females age 40 and over
Mammography Screening Services Maximum	▪ In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)	▪ In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)	▪ In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)

Pregnancy Related Expenses *(GR-9N 11-100 01 OH)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include the charges for post discharge follow-up care for a mother and her newborn ordered and supervised by a **physician**. Services related to maternity follow-up care are covered whether such services are provided in a medical setting or in the home.

If the mother is discharged earlier than the minimum lengths of stay indicated above, all follow-up care received within 72 hours after discharge is covered without regard to medical necessity.

If the mother receives at least the minimum number of hours of inpatient care shown above, follow-up care that is not medically necessary will not be covered.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Off-Label Use *(GR-9N 13-005 01 OH)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, at **Aetna's** sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations.

Continuing Coverage After You Terminate Employment *(GR-9N 31-015-01 OH)*

You have the option to continue your and your dependent's health care benefits for up to 6 months if coverage would otherwise end because your employment ends.

You are eligible for this continuation but only if you:

- have been covered under the group policy for 3 months before employment ended;
- are entitled to unemployment compensation benefits when employment ended;
- are not or do not become covered or eligible for coverage by Medicare; and
- are not or do not become covered or eligible for comparable benefits under any other group or individual plan.

Your employer will notify you of this option at the time your employment ends and the amount of the contribution required.

You must elect continuation and pay the required contribution to the employer no later than the earlier of:

- 31 days after the date your coverage would otherwise terminate;
- 10 days after the date your coverage would otherwise terminate, if notice is given before that date; or
- 10 days following the date coverage would otherwise terminate, if notice is given after that date.

Coverage under this continuation will end on the first to occur of:

- You cease to be eligible for this continuation as shown above;
- 6 months following the date coverage would otherwise terminate due to termination of employment;
- You fail to make the required contribution; or
- The group policy terminates.

Coordination Disputes *(GR-9N 33-015 01 OH)*

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686- 1526.

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note

Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical 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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Oregon ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Oregon. **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 Oregon, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents *(GR-9N 029-010 02 OR)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules outlined in the *Coverage for Domestic Partner* section below; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N 29-010 01 OR)*

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under Oregon law for entering into a domestic partnership; and
- jointly execute and register a Declaration of Domestic Partnership with the county clerk; or
- complete and sign a "Declaration of Domestic Partnership" which is acceptable to your Employer.

Prosthetic and Orthotic Devices *(GR-9N-11-110-02 OR)*

Covered expenses include charges made for internal and external prosthetic and orthotic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic and orthotic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic and orthotic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes those in the most recent Medicare Fee Schedule.

The plan will not cover expenses and charges for, or expenses related to:

- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

Hearing Aids

Covered expenses, for a dependent child to age 18 or older if a full-time student in an accredited educational institution, includes charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written by a physician or audiologist during a hearing exam.

This Plan covers charges for 1 hearing aid for each ear in any one period of 48 consecutive months up to the maximum benefit shown in your *Schedule of Benefits*.

Hearing Aids	80% after Calendar Year **deductible**	60% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Maximum Benefit per 48 month period	$4,000	$4,000	$4,000

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **deductible**, **coinsurance** and maximum benefit limits.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Smoking Cessation

Covered expenses for a covered person who is 15 years of age or older include physician services, prescription drugs and over-the-counter medications prescribed by a physician for a tobacco use cessation program.

A tobacco use cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco use cessation. A tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco Cessation Physician Services	Cost sharing is based upon the type of physician providing the service.	Cost sharing is based upon the type of physician providing the service.	Cost sharing is based upon the type of physician providing the service.
Prescription Drugs and Over-the-Counter Medications	100% per prescription, medication or refill, after Calendar Year **deductible**	60% per prescription, medication or refill, after Calendar Year **deductible**	80% per prescription, medication or refill, after Calendar Year **deductible**

The following exclusion has been removed:

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

Smoking Cessation

Tobacco Cessation. For a covered person who is 15 years of age or older, the prescription drug plan covers prescription drugs and over-the-counter medications prescribed by a physician that are recommended by a physician and follow the United States Public Health Services guidelines for tobacco use cessation.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to food.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	South Carolina ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 South Carolina. **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 South Carolina, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Cancer Screenings

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

- 1 baseline mammogram for covered females age 35 to 39
- 1 mammogram every 12 months for covered females age 40 and over
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

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.

Autism Spectrum Disorders

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician** as part of a Treatment Plan; and

- The covered child is diagnosed with Autism Spectrum Disorder with onset prior to age three; and
- The **covered expenses** are incurred prior to attainment of age sixteen and older if the covered child is in high school.

Applied Behavioral Analysis is an educational service that is the process of applying interventions:
- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified

Coverage for Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the *Schedule of Benefits*.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Autism Spectrum Disorder *(GR-9N S-10-061-02-SC)*			
	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

Pregnancy Related Expenses *(GR-9N 11-100 01)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Cleft Lip or Palate Treatment *(GR-9N 011-155 01)*

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;

- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Continuing Medical Coverage *(GR-9N 31-015-02 SC)*

The following applies only if you have been covered for Medical Coverage for at least 6 months in a row.

If coverage ends, any Medical Coverage in force for you and your dependents may continue after it would otherwise terminate but only if:

- Termination is not due to non-payment of required contributions.
- The coverage is not replaced within 62 days by other group coverage.
- The group contract is still in force as to your Eligible Class.

You will be notified by your employer of your right to make application for continuation of the group policy and the amount of premium required to be paid before the start of each contract month.

Your and your dependent's coverage will end when the first of the following occurs:

- The end of a 6 month period following the end of the group contract month in which coverage would otherwise cease.
- The date you are eligible for coverage under any group plan that provides like benefits or services.
- You fail to make required contributions.
- The date the person is or could be covered by Medicare.
- Health benefits discontinue as to employees of your former Employer.

Coverage for a dependent will cease when the person:

- ceases to be a defined dependent; or
- becomes eligible for other coverage under the group contract.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Tennessee ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Tennessee. **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 Tennessee, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Clinical Trial Expenses *(GR-9N-11-094-01 TN)*

This plan will pay for the **medically necessary** and routine patient care **physician** and facility charges incurred by a person who is enrolled in a Phase I, Phase II, Phase III or Phase IV Clinical Trial study. A "clinical trial" means a patient research study that is designed to evaluate a new drug, medical device, or service that falls within a Medicare benefit category and is not statutorily excluded from coverage. Such proposed treatment:

- must be intended to treat cancer;
- must have therapeutic intent; and
- must be recommended by the person's treating **physician** as having meaningful potential benefit to the person based upon at least two documents of medical and scientific evidence.

The clinical trial must meet the following criteria:

- It must involve a drug that is exempt under federal regulations from new drug application.
- It must be approved by centers or cooperative groups that are funded and sponsored by the National Institutes of Health, the Food and Drug Administration (FDA) in the form of an investigational new drug application, the Department of Defense, or the Department of Veterans Affairs.

Charges for **covered expenses** incurred by a person for:

- health care services for the appropriate monitoring of the person during the clinical trial; and
- the treatment;
- provided in the clinical trial; and
- that is a result of unintended medical complications caused by the treatment provided in the clinical trial;

are payable on the same basis as any illness or injury covered under this Plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including, but not limited to:

- **Aetna's** Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Covered expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to **precertification** and referral requirements.

Limitations
Unless specified above, the clinical trial benefit does ***not*** cover charges for:

- any drug, device, or service that is not approved by the FDA and that is associated with the clinical trial; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research;
- any expenses related to participation in the clinical trial, including travel, housing, and other expenses;
- any expenses incurred by a person accompanying the person; and
- any expenses related to determining eligibility for participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the person.

Off-Label Use *(GR-9N-11-110-01 TN)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification, step-therapy** or other **Aetna** requirements or limitations.

Recovery of Overpayments *(GR-9N-32-015-01 TN)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right will not apply more than 15 months as to you and 18 months as to a health care provider after the overpayment was made unless:

- the overpayment was made due to failure to provide complete information, fraud or material misstatements (on the part of you or the health care provider); or
- you or the health care provider has otherwise agreed to return the overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Vermont ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Vermont. **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 Vermont, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Obtaining Coverage for Dependents *(GR-9N 29-010 01 VT)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; your **civil union partner**; or
- Your domestic partner who meets the rules set by your employer; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody;
- **Your civil union partner's** children; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Routine Cancer Screenings (GR-9N 11-00501 VT)

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

- 1 baseline mammogram every 12 months for covered females age 35 to 39
- 1 mammogram every 12 months for covered females age 40 and over
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

Pregnancy Related Expenses *(GR-9N 11-100-01 VT)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

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

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Craniofacial Disorders*(GR-9N 11-150-01 VT)*

The plan will cover charges for diagnosis and treatment, including surgical and non-surgical procedures, for a musculoskeletal disorder that affects any bone or joint of the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect or pathology.

Not Covered:

- Charges for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth or alveolar ridge.
- Charges to the extent covered under any other part of the plan.

Continuation of Coverage

Continuing Health Care Benefits *(GR-9N 31-015 01 VT)*
Continuing Coverage for Dependents Due to Divorce, Legal Separation or Ceasing to be an Eligible Dependent *(GR-9N 31-015 01 VT)*

If health care benefits for your spouse or child terminates:

- Because of divorce or legal separation; or
- Because of the child ceasing to be an eligible dependent;

The person whose coverage terminates may continue the coverage in force by continuing to make premium payments.

Coverage may only be continued if:

- The person has been covered for dependents coverage under the plan for at least 3 months in a row before coverage would terminate;
- The person, on the date coverage would terminate, does not become eligible under any other group plan or under Medicare.

The person has to make request in writing for this continuation. This must be done within 30 days of the date as of which coverage would have terminated. Premium payments must be continued.

Coverage will end on the first to occur of:

- The end of the 6 month period which starts on the date the person's coverage would otherwise terminate.
- The date the person is eligible for like coverage under any other group plan or under Medicare.
- The date the person fails to make any required contribution.
- The date health benefits are discontinued for employees of the class of which you are a member.
-

If any coverage being continued ceases, the person may apply for a personal policy in accordance with the section *Converting to an Individual Health Insurance Policy*.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Washington ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 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 Osteopathy (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**.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	West Virginia ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 West Virginia. **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 West Virginia, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

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

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

- 1 mammogram every 12 months for covered females age 35 and over;
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are **covered expenses** if you are age 50 and older, or less than 50 but symptomatic, 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.
- 1 fecal occult blood test every 12 months.

The above age and frequency limits do not apply to a person at high risk for the type of cancer screened.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01 WV)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin- and non-insulin-dependent diabetes and gestational diabetes.

Supplies: Include but are not limited to:

- Blood glucose monitors;
- Monitor supplies;
- Insulin;
- Injection aids;
- Syringes;
- Insulin infusion devices;
- Pharmacological agents for controlling blood sugar;
- Orthotics.

Self-Management Education on the proper self-management and treatment of diabetes, including information on proper diets. This will be limited to (1) visits upon the diagnosis of diabetes; (2) visits when a physician identifies or diagnoses a significant change in the person's symptoms or condition that requires changes in self-management; and (3) when new medications or therapeutic processes relating to the person's treatment or management of diabetes have been identified as necessary.

Important Reminder
There are limits for reeducation or refresher education. Refer to the *Summary of Benefits* for details on these limits.

Contraception Services

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

- Contraceptive drugs and contraceptive devices that by law need **physician's prescription and that** 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.
- Charges incurred for duplicate, lost, stolen or damaged contraceptive drugs and devices.

Note: When your employer is a "religious" employer that:

- qualifies as a tax-exempt organization under 26 United States Code, Section 501 (c) (3); and
- requested an exclusion under the Plan for outpatient contraceptives and outpatient contraceptive services because such coverage conflicts with the employer's religious beliefs and practices; and either:
  - is listed in the Official Catholic Directory published by P.J. Kennedy and Sons; or
  - meets the definition of a "religious" employer as defined in 26 United States Code, Section 3121 (w) (3) (A).

Then outpatient contraceptive drugs and devices and outpatient contraceptive services are covered under this Plan only if they are:

- used to treat a medical condition that is covered under this Plan; or
- are necessary to preserve the life or health of the covered person.

You must submit proof, satisfactory to Aetna, that the incurred expenses meet one of the requirements, specified above, with the claim.

Treatment of a Serious Mental Illness *(GR-9N 11-170 01 WV)*

Covered expenses for the treatment of **serious mental illness by behavioral health providers** include those incurred:

- During a **stay** in a **hospital** or **residential treatment facility**;
- For **partial confinement treatment**; and
- For outpatient treatment.

Benefits are payable in the same way as those for any other disease. Coverage under this benefit does not include treatment of a **mental disorder**.

Treatment of Mental Disorders *(GR-9N 11-170 01 WV)*

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

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. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

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

Partial Confinement Treatment *(GR-9N 34-080-01 WV)*

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **mental disorders or serious mental illnesses**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.

- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

Mental Disorder *(GR-9N 34-065-01 WV)*

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder is not a serious mental illness as defined herein**.

Serious Mental Disorder *(GR-9N 34-095-01 WV)*

This means the following **serious mental disorders** as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of **Mental Disorders**":

- Bipolar disorder.
- Depressive disorder.
- Anxiety disorder.
- Panic disorder.
- Anorexia and bulimia.
- Pervasive developmental disorder (including Autism).
- Schizoaffective disorder.
- Schizophrenia.

Treatment is generally provided by, or under the direction of, a **behavioral health provider** such as a **psychiatric physician**, a psychologist, or a psychiatric social worker.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment Of Serious Mental Illness and Non-Serious Mental Illness *(GR-9N S-10-60 WV)*			
Serious Mental Illness	Note: These covered expenses are paid on the same basis as any other inpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other inpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other inpatient disease or illness.
Non-Serious Mental Illness	Note: These covered expenses are paid on the same basis as any other inpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other inpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other inpatient disease or illness.

Outpatient Treatment Of Serious Mental Illness and Non-Serious Mental Illness			
Serious Mental Illness	Note: These covered expenses are paid on the same basis as any other outpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other outpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other outpatient disease or illness.
Non-Serious Mental Illness	Note: These covered expenses are paid on the same basis as any other outpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other outpatient disease or illness.	Note: These covered expenses are paid on the same basis as any other outpatient disease or illness.

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:	University of Pennsylvania Postdoctoral Insurance Plan
Group Policy No.:	GP-861472
Rider:	Wisconsin ET Medical
Issue Date:	January 19, 2016
Effective Date:	January 1, 2016

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 Wisconsin. **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 Wisconsin, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Benefits payable under this *Booklet-Certificate* are primarily based on recognized charges or scheduled benefits which may be less than the actual charge.

For benefit information questions, please contact:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna's** toll free customer service number found on your ID card or visit **Aetna's** website at www.Aetna.com.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 27 years of age.

Special Enrollment Periods *GR-9N-29-015-02 WI)*

If You Adopt a Child

Your plan will cover a child who is placed for adoption. ("Placed for adoption" means any of the following: 1) the department, a county department or a child welfare agency licensed under the Wisconsin Code places a child in the insured's home for adoption and enters into an agreement under the Code with the insured; 2) a court under the Wisconsin Code orders a child placed in the insured's home for adoption; 3) a sending agency as defined in the Wisconsin Code places a child in the insured's home for adoption, and the insured takes physical custody of the child at any location within the United States; 4) the person bringing the child into this state has complied with the Wisconsin code, and the insured takes physical custody of the child at any location within the United States; or 5) a court of a foreign jurisdiction appoints the insured as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the insured's home for the purpose of adoption by the insured under the Wisconsin Code.)

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Covered expenses for children from birth to age 6 also include:

- Diphtheria;
- Haemophilus influenza type B;
- Hepatitis A;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis;
- Polio;
- Rubella;
- Tetanus; and
- Varicella.

May not be subject to any deductibles, copayments, or coinsurance.

Routine Cancer Screenings

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

- Routine Mammogram:
    - A baseline mammogram for women between the ages of 35 to 40; and
    - A mammogram every two years; or more frequently based on the recommendation of the women's physician for women ages 40 to 50;
    - A mammogram on an annual basis for women 50 years of age and older.

Outpatient Equipment, Supplies and Diabetic Self-Management Education Program Expenses *(GR-9N-11-135-02 WI)*

Covered expenses include charges for the following expenses incurred in connection with the treatment of diabetes (including insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes):

- Equipment;
- Supplies;
- Outpatient self-management training and education;
- Medications.

Charges for a diabetic self-management education program are covered; but only if:

- the person is a diabetic who is covered under this Policy; and not confined in a hospital or skilled nursing facility as a full-time inpatient; or
- the person is covered under this Policy; and cares for; or helps care for a diabetic who is covered under this Policy and not confined in a hospital or skilled nursing facility as a full-time inpatient.

Charges include tuition and fees.

A "diabetic self-management education program" is a scheduled program on a regular basis which is designed to instruct a person in the self-management of diabetes. It is a day care program of educational services and self-care training. All the following requirements must be met.

- A physician must direct and supervise the program.
- The program's services and training must be rendered by health care professionals who are familiar with diabetes and its treatment. This includes physicians; R.N.'s registered pharmacists; registered dieticians; and licensed social workers.
- The program must include:
  - An assessment of the diabetic's needs and skills. This must be done:
    - by the health care professionals who render the service; and
    - before the program starts and after it ends.
  - An education plan designed for the diabetic's condition and skills.
  - At least a total of 10 hours of one on one or group instructions.
  - At least one dietary counseling session for the diabetic and the persons who help in his or her care.
  - A discussion of:
    - the history of diabetes;
    - psycho-social factors which affect the diabetic and his or her family;
    - complications and related symptoms;
    - special general health care concerns. (These include hygiene and pregnancy care if appropriate.)
  - Training in:
    - dietary and nutritional planning;
    - procedures for testing and monitoring of blood sugars; and
    - adjusting medications or diet to correspond to activities and exercises done.
    - Provision for at least one follow-up evaluation. This is done after the person completes the program.

Not included as covered medical expense are program expenses incurred for a diabetic education program whose only purpose is weight control or a diabetic education program that is available to the public at no cost

Kidney Disease Treatment			
Kidney Disease Treatment Maximum	$30,000 per Calendar Year	$30,000 per Calendar Year	$30,000 per Calendar Year

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Jaw Joint Disorder Treatment *(GR 9N 11-150 01 WI)*

This plan pays for charges made by a **physician** for the medically necessary surgical or non-surgical treatment (including intraoral splint therapy devices) for correction of temporomandibular joint disorders. Such treatment will be considered medically necessary if:

- caused by congenital, development or acquired deformity, disease or injury;
- the procedure or device is to control or eliminate infection, pain, disease or dysfunction; and
- under accepted standards of the profession of the medical provider rendering the service the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

Benefits are payable up to the jaw joint disorder maximum shown in the *Schedule of Benefits*.

No benefits are payable for:

- Cosmetic or elective orthodontic care, periodontic care or general dental care.

Hospital or ambulatory surgery center charges incurred, and anesthetics provided in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

- The individual is a child under the age of 5.
- The individual has a chronic disability as defined in the Wisconsin Code.
- The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

Treatment of Mental Disorders *(GR-9N-11-170-01 WI)*

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment
Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment
Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

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. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Transitional Treatment Arrangements
Covered expenses for transitional treatment arrangements are covered. Benefits will be payable, after any applicable Deductible amount, at the covered percentage up to the maximum days or maximum benefit for such expenses incurred in any Calendar Year.

The applicable Deductible amounts, covered percentages, maximum days, and maximum benefits are shown on the Summary of Benefits.

For all charges incurred for:

- inpatient treatment;
- transitional treatment arrangements; and
- outpatient treatment;

of alcoholism, drug abuse or mental disorders, no benefits will be paid for charges incurred which are in excess of $7,000 in any one Calendar Year.

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

Skilled Nursing Inpatient Facility			
Maximum Days per period of confinement	120 days	120 days	120 days

Continuing Coverage for Dependents After Your Death
If you should die while enrolled in this plan, your dependent's health care coverage, if applicable will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended;
- A request is made for continued coverage within 30 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 18 month period following your death;
- He or she no longer meets the plan's definition of "dependent;"
- He or she becomes eligible for comparable benefits under this or any other group plan; or

- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.

Continuing Coverage Full-time Student on Medical Leave *(GR-9N-31-015-03 WI)*

You may continue health care benefits for a full-time student dependent child, if coverage ends due to a medically necessary leave of absence.

A full-time student is only entitled to continue coverage if he or she submits to Aetna documentation and certification of the medical necessity of the leave of absence from the full-time student's attending **physician**. The date on which the full-time student ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which the coverage continuation begins.

Your full-time student dependent child's coverage will end when the first of the following occurs:

- Does not intend to return to school full-time.
- Becomes employed full-time.
- Becomes eligible for comparable benefits under this or any other group plan.
- Marries and is eligible for coverage under his or her spouse's health care coverage.
- Ceases to be defined as a full-time student.
- Full-time student coverage ceases under this Plan.
- One year has elapsed since the full-time student's coverage continuation began and the full-time student has not returned to school full-time.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)