# Aetna Life Insurance Company

Hartford, Connecticut 06156

**Amendment**

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|---|---|
| **Policyholder**: | California Institute of Technology |
| **Group Policy No.**: | GP-869105 |
| **Rider**: | Texas ET Dental |
| **Issue Date**: | November 22, 2018 |
| **Effective Date**: | January 1, 2019 |
| **Texas**: | Dental Expense Coverage |

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 dental 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 Texas. If the benefits for covered expenses in this rider have no corresponding covered expense in the booklet certificate, then the covered expenses in this rider are in addition to the benefits provided under your booklet certificate. The benefits for covered expenses in this rider replace any benefits for covered expenses for the same benefit in the booklet certificate.

Except as otherwise shown in this rider, the benefits in this rider are subject to the annual limits and overall coverage year maximum (if any) specified in your booklet certificate.

**IMPORTANT NOTICE**

To obtain information or make a complaint:

**You may call Aetna's toll-free telephone number for information or to make a complaint at**

**1-800-MY-Health (694-3258)**

**You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:**

**1-800-252-3439**

**You may write the Texas Department of Insurance at:**

**Texas Department of Insurance**
**P.O. Box 149104**
**Austin, TX 78714-9104**
**FAX No. (512) 475-1771**

**Premium or Claim Disputes:**
**Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.**

**Notice:**
**This notice is for information only and does not become a part or condition of your Policy.**

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

**Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al**

**1-800-MY-Health (694-3258)**

**Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:**

**1-800-252-3439**

**Puede escribir al Departamento de Seguros de Texas:**

**Texas Department of Insurance**
**P.O. Box 149104**
**Austin, TX 78714-9104**
**FAX No. (512) 475-1771**

**Disputas Sobre Primas o Reclamaciones:**
**Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.**

**Aviso:**
**Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Póliza.**

**Coverage for Dependent Children**
To be eligible, a dependent child must be:

- Unmarried and under age 25.

To be eligible, a dependent grandchild must be:

- The unmarried child of your child; and
- Under age 25; and
- Supported by you for Federal Income Tax purposes on the date of his or her initial application for coverage. Coverage will not terminate solely due to the child's loss of such Federal Income Tax dependency status; or
- Any age, if medically certified as disabled and dependent on the parent.

Your children can include the following:

- Your biological children;
- Your stepchildren;
- Your legally adopted children; including any child placed with you for adoption and any child for whom you are a party in a suit in which the adoption of the child is sought;
- Your foster children;
- Any child for whom you or your covered spouse is under court order for medical support. This child is covered immediately upon Aetna's notification of such order;
- 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.

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

# 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 the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. 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, preauthorization 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, 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" or other medical payments coverage available under any automobile policy including 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.

# Which Plan Pays First *(GR-9N 33-010 01-TX)*

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, member, 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, member, 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 is earlier in the year if:
        i. The parents are married or living together whether or not married;
        ii. 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.
     C. 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; and then
        - The plan of the noncustodial 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, member, 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, member, subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses 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.

## Continuing Health Care Benefits

You may continue coverage under the plan which terminates for you and your dependents, for any reason, except involuntary termination of employment due to cause, but only if you have been covered under this plan for at least 3 months in a row prior to such termination.

You must request the continuation in writing within 31 days of the later to occur of:

- the date coverage would otherwise cease; and
- the date your employer or group policy holder provides you with the notice of your right to continue coverage.

Premium payments must be continued. The required contribution for continued coverage may not exceed 102% of the group rate.

Continuation for a person may not terminate until the earliest of:

- 6 months after the date the election is made.
- The end of the period for which required contributions are made.
- The date the person is or could be covered by Medicare.
- The date the person is covered or is eligible for similar benefits under another medical expense plan.
- The date the person has similar benefits available pursuant to any state or federal law.

Coverage for a dependent will cease earlier when the person:

- ceases to be a defined dependent under this plan; or
- becomes eligible for other coverage under the group contract.

You and your dependents can elect this continuation in lieu of or following any other continuation offered under this plan. If this continuation is elected, the conversion privilege will not be available.

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

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

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.

**Aetna** will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

### Continuation of Coverage During a Labor Dispute

This continuation of coverage provision only applies if this plan is subject to a collective bargaining agreement.

If your coverage under this plan would cease because you cease work due to a labor dispute, you can arrange to continue your coverage during your absence from work if the Texas Insurance Code applies. Coverage may continue for up to 6 months.

Continuation will cease when the first of these events occurs:

- You fail to make the required payments to your collective bargaining unit representative.
- Your representative fails to make the required premium payments to Aetna.
- You go to work full time for any other employer.
- Any premium due date when less than 75% of the affected employees have elected to continue their coverage.
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable rate in effect on the date you cease work. **Aetna** has the right to change premium rates under the terms of this Plan at any time during this continuation of coverage.

# Reimbursement to Texas Department of Human Services

All health expenses payable on behalf of your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify Aetna in writing that the following applies and you request such direct payment be made:

- the Texas Department of Human Services is paying benefits for your child under the financial and medical assistance service program administered pursuant to the Human Resource Code; and you either
- have possession of or access to the child pursuant to a court order; or
- are not entitled to possession of or access to the child and are required by the court to pay child support.

The changes set forth apply to covered persons residing in **Texas**.

The following changes are made to the Booklet:

- All references to "network providers" are changed to "Contracting providers."
- All references to "out-of-network providers" are changed to "Non-contracting providers."
- All references to “network” are changed to “contracting”; all references to “out-of-network” are changed to “non-contracting.”
- All references to “Preferred Provider Organization” and “PPO” are deleted.

The **Additional Items Not Covered By a Health Plan** section of your booklet-certificate has been amended to remove the following items:

**Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

# Comprehensive Dental Plan

## Schedule of Comprehensive Dental Benefits *(GR-9N-S-21-005-01TX)*

| PLAN FEATURES | CONTRACTING PROVIDERS | NON CONTRACTING PROVIDERS |
|---|---|---|
| Calendar Year **Deductible** | Individual $50<br>Family $150 | Individual $50<br>Family $150 |

The Calendar Year **deductible** applies to all covered expenses.

**Calendar Year Maximum Benefit**
Calendar Year Maximum: $1,000

The most the plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year maximum benefit applies to **contracting providers and non contracting providers covered** dental expenses combined.

**Orthodontic Lifetime Maximum Benefit**
Orthodontic Lifetime Maximum: $1,000

Mark T. Bertolini
Chairman, Chief Executive Officer and President

# Aetna Life Insurance Company
Hartford, Connecticut 06156

**Amendment**

| | |
|---|---|
| **Policyholder:** | California Institute of Technology |
| **Group Policy No.:** | GP-869105 |
| **Rider:** | Texas Complaint and Appeals Health Rider |
| **Issue Date:** | November 22, 2018 |
| **Effective Date:** | This Booklet-Certificate Amendment is effective on January 1, 2019 |

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 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 determination by **Aetna** that the health care services provided or proposed to be provided to the covered person are not **medically necessary** or appropriate, or are **experimental or investigational**.

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

- 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; or
- A decision that the service or supply is not **Medically Necessary**.

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

**Claim Subject to Preauthorization:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**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 previously approved course of treatment.

**Experimental or Investigational:** With regard to an **adverse benefit determination**, this means a service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

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

**Post-Service Claim:** Any claim that is not a "**Claim Subject to Preauthorization**."

## 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 benefit 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. 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**.

### Time Frames for Adverse Benefit Determination Notifications

***If the claim is being denied for post-stabilization care requested by the treating physician or other health care provider following Emergency Medical Care, (an "urgent claim"):***

**Aetna** will notify the treating **physician** or other health care provider within one hour of notification of the request.

***If the patient is hospitalized at the time the claim is made (an "urgent claim"):***

**Aetna** will make notification by telephone or electronic transmission of a claim decision as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

If more information is needed to make a decision in either of these two circumstances described, above, **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 **physician** 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.

***If the patient is not hospitalized at the time the claim is made:***

**Aetna** will make notification of a claim decision within three working days, in writing, to the provider of record and the patient.

***In all other circumstances, other than as described in the sections, above or below:***

**Aetna** will make written notification of an **adverse benefit determination** within the time appropriate to the circumstances relating to the delivery of the services and to the patient's condition.

**Contents of Notifications**
If it is an **adverse benefit determination Aetna** will send notice of that determination accompanied by the following:

(1) the principal reasons for the **adverse benefit determination**;
(2) the clinical basis for the **adverse benefit determination**;
(3) a description of or the source of the criteria used as the guideline in making the **adverse benefit determination;** and
(4) a description of the procedure for the appeal process, including notice of the covered person's right to appeal an **adverse benefit determination** to an independent External Review Organization and of the procedures to obtain that review. If the covered person has a life-threatening condition, you the covered person have the right to an immediate independent External Review. **Aetna's** appeal process in this circumstance is not required.

## Concurrent Care Claim Extensions, Reductions or Terminations

If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, **Aetna** will make notification by telephone or electronic transmission of a claim decision of regarding concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within two working days.

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.

## Post-service Claims

**Aetna** will make notification of a post-service claim decision as soon as possible but not later than 30 calendar days after the post-service claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the covered person within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

## Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you, or the person you authorize to do so must write Aetna Customer Service. 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 written response within 30 calendar days of the receipt of the complaint, unless additional 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**. It will also provide an option to request an external review of the **adverse benefit determination**. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to **Aetna**.

Your appeal may be submitted orally or in writing and should include:

- Your name;
- Your employer'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 Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the toll-free telephone number listed on such notice.

**Aetna** will acknowledge receipt, in writing, of your **appeal** within 5 working days of receiving it.

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.

## Group Health Claims

The review of an appeal of an **adverse benefit determination** shall be provided by an **Aetna** physician not involved in making the **adverse benefit determination**.

**Non-Expedited Appeals**
**(Applies for Claims Subject to Preauthorization and Post-Service Claims)**

**Claims Subject to Preauthorization**
**(May Include Concurrent Care Claim Reduction or Termination)**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

If an **adverse benefit determination** concerning specialty care is upheld upon appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. The **adverse benefit determination** will be reviewed by a provider in the same or similar specialty as that which is the subject of the **adverse benefit determination** and the review will be complete within 15 working days of its receipt of the request.

**Post-Service Claims**
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

## Expedited Appeals

***(Applies for Claims for Post-Stabilization Care following an Emergency or for Claims When the Patient is Hospitalized -- May Include Appeals Regarding Concurrent Care Claim Reductions or Terminations of Hospital Stays)***

Aetna shall issue a decision on the appeal of an **adverse benefit determination** for an Urgent Care Claim within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the Appeal has been received by **Aetna**. If **Aetna** has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is an urgent claim, you may immediately appeal **Aetna's adverse benefit determination** to an independent External Review Organization. You are not required to first comply with **Aetna's appeals** process. Please see the section entitled "External Independent Review", below.

## External Independent Review

If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician,** selected by an independent External Review Organization, who has expertise in the problem or question involved.

You may request a review by an independent External Review Organization assigned to the appeal by the Texas Department of Insurance for any appeal related to an **adverse benefit determination** concerning a claim subject to preauthorization involving a decision that the service, supply, or non-formulary drug is **experimental** or **investigational** and/or is not **medically necessary**.

If your **adverse benefit determination** is for a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust **Aetna's** internal appeals processes.

The claim 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.

Aetna 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 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.

## Expedited Reviews

An expedited review is possible if either (a) or (b), below applies:

(a) You have an urgent claim, as described above. The External Review Organization will inform both you and **Aetna** of the decision within four business days or fewer, (depending on the urgency of the medical specifics of the case), from the date of receipt of the request for the expedited External Review of the urgent claim. If the External Review Organization provides an oral notification, it must follow that oral communication with a written notice of the decision within 48 hours of the oral notification.

(b) Your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Such 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 the external review.
For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

**Important Note:**

If **Aetna** does not meet all of the **appeal** timeline requirements outlined above, you are considered to have exhausted the **appeal** requirements and may proceed with an **External Review.**

## Exhaustion of Process

Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

You may not:

- contact the Texas Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with the Texas Department of Insurance; or
- establish 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**:

  (1) before the 61st day after the date written proof of loss is filed as required under the policy; or
  (2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

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)

Rider: Appeals
Issue Date: November 22, 2018