Amendment

Amendment effective date: January 1, 2020

Your group coverage has changed. This amendment to your booklet and schedule of benefits reflect the changes. It is effective on the date shown above and it replaces any other medical amendment you have received before.

The following language is revised in the Medical necessity, referral and precertification requirements section of your booklet:

What types of services require precertification?
Precertification is required for the following types of services and supplies:

<table>
<thead>
<tr>
<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stays in a hospital</td>
<td>Cosmetic and reconstructive surgery</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Non-emergency transportation by fixed wing airplane</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
<td>Transcranial magnetic stimulation (TMS)</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
<td>Applied behavior analysis</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for treatment of mental disorders and substance abuse</td>
<td>Partial hospitalization treatment – mental disorder and substance abuse diagnoses</td>
</tr>
</tbody>
</table>

You can contact us to get a list of the services that require precertification. The list may change from time to time.

Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification.

The following language is revised in the Eligible health services under your plan-Physicians and other health professionals section of your booklet:

Physician services
Eligible health services include services by your physician to treat an illness or injury. You can get those services:

- At the physician's office
- In your home
- In a hospital
- From any other inpatient or outpatient facility
- By way of telemedicine
Important note:
Other than for behavioral health, your plan covers **telemedicine** only when you get your consult through a **provider** that has contracted with **Aetna** to offer these services.

For behavioral health services, all in-person office visits covered, by either **network** or **out-of-network providers**, with a **behavioral health provider** are also covered if you use **telemedicine** instead.

**Telemedicine** may have different cost sharing. See the schedule of benefits for more information.

The following language is revised in the Eligible health services under your plan - Physicians and other health professionals section of your booklet:

**Alternatives to physician office visits**

**Walk-in clinic**

**Eligible health services** include, but are not limited to, health care services provided at walk-in clinic for:

- Scheduled and unscheduled visits for **illnesses and injuries** that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license

The following important note is removed from the Applied behavior analysis provision within the **Eligible health services under your plan - Specific conditions section** of your booklet:

**Important note:**

Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

The following inpatient language is added within the Mental health treatment provision and the Substance related disorders treatment provision within the **Eligible health services under your plan - Specific conditions section** of your booklet:

Your plan will cover the extra expense of a private room when appropriate because of your medical condition.

The following language is added within the **Eligible health services under your plan - Specific therapies and tests section** of your booklet:

**Short-term rehabilitation services**

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the **Short-term rehabilitation services** section in the schedule of benefits.

The following language replaces the **Medication synchronization** provision within the **Eligible health services under your plan - Outpatient prescription drugs** section of your booklet:
Prescription drug synchronization
If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your prescription drugs.

The following language is removed within the Eligible health services under your plan- Outpatient prescription drugs section of your booklet:

Partial fill dispensing program
Our program allows only a partial fill of your prescription. Your out of pocket expenses will be prorated accordingly. You can access the list of these prescription drugs by calling the toll-free number on your ID card or log on to your secure member website at www.aetna.com.

The following language is removed from the What your plan doesn’t cover – some eligible health service exceptions section of your booklet:

Counseling
- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

The following language is revised in the What your plan doesn’t cover – some eligible health service exceptions section of your booklet:

Court-ordered services and supplies
This includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered benefit under your plan.

The following language is removed from the What your plan doesn’t cover – some eligible health service exceptions section of your booklet:

Early intensive behavioral interventions
Examples of those services are:
- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

The following language is revised in the What your plan doesn’t cover – some eligible health service exceptions section of your booklet:

Educational services
Examples of those services are:
- Any service or supply for education, training or retraining services or testing, except where described in the Eligible health services under your plan – Diabetic equipment, supplies and education. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs

Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

The following language is revised in the What your plan doesn’t cover – some eligible health service exceptions section of your booklet:
Telemedicine

- Services, other than behavioral health services, given by providers that are not contracted with Aetna as telemedicine providers
- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

The following language is revised in the What your plan doesn't cover – some eligible health service exceptions section of your booklet:

Wilderness treatment programs
See Educational services within this section

The following provision is added to the What your plan doesn't cover - some eligible health services exceptions-General Exclusions section of your booklet.

Behavioral health treatment
Services for the following categories (or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):

- Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

The following language replaces the Mental health treatment exclusion in the Additional exceptions for specific types of care-Specific conditions section of your booklet:

Mental health and substance related disorders treatment
The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the Eligible health services - Preventive care section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

The following language is revised in the Who provides the care-Your PCP section of your booklet:
Your PCP
We encourage you to access eligible health services through a PCP. They will provide you with primary care.

A PCP can be any of the following providers available under your plan:
- General practitioner
- Family physician
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

The following language is revised within the External review provision in the When you disagree-claim decisions and appeal procedures-External review section of your booklet:

You must submit the Request for External Review Form:
- To Aetna
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

Aetna will contact the ERO that will conduct the review of your claim.

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

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

The following language is revised in the Glossary section of your booklet:

Mental disorder
A mental disorder is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of mental disorder is in the most recent edition of The International Classification of Diseases, Tenth Edition (ICD-10).

The following term is revised in the Glossary section of your booklet:
**Negotiated charge**

*For health coverage, this is either:*

- The amount a network provider has agreed to accept
- The amount we agree to pay directly to a network provider or third-party vendor (including any administrative fee in the amount paid)

for providing services, prescription drugs or supplies to plan members. This does not include prescription drug services from a network pharmacy.

We may enter into arrangements with network providers or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the negotiated charge under this plan.

*For prescription drug services from a network pharmacy:*

The amount we established for each prescription drug obtained from a network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the network pharmacy or to a third-party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may not change the negotiated charge under this plan.

The following language is revised in the Glossary section of your booklet-certificate:

**Telemedicine**

A consultation between you and a provider who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls
- Any other method required by state law

The following language is revised in the Glossary section of your booklet:
Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near, or within a:
- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a walk-in clinic:
- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a hospital
- Physician's office
- Urgent care facility

The following is added to or replacing all provisions of the Walk-in-clinic sections of your schedule of benefits:

<table>
<thead>
<tr>
<th>Alternatives to physician office visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Walk-in clinic visits</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Non-emergency services</td>
</tr>
<tr>
<td>Preventive immunizations</td>
</tr>
<tr>
<td>Immunization limits</td>
</tr>
<tr>
<td>For details, contact your physician</td>
</tr>
<tr>
<td>Screening and counseling services</td>
</tr>
<tr>
<td>Screening and counseling limits</td>
</tr>
</tbody>
</table>
Important note:
Designated network provider
A network provider listed in the directory under Best results for your plan as a provider for your plan.

Non-designated network provider
A provider listed in the directory under the All other results tab as a provider for your plan.
See the Contact us section if you have questions.

You will pay less cost share when you use a designated network walk-in clinic provider. Non-designated network walk-in clinic providers are available to you, but the cost share will be at a higher level when these providers are used.

The following language has been revised in the Eligible health services-Specific conditions Mental health treatment and Substance related disorders treatment-outpatient benefits in your schedule of benefits:

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider</td>
</tr>
<tr>
<td>Includes telemedicine consultation</td>
</tr>
</tbody>
</table>

The telemedicine cognitive behavioral therapy consults language in the Outpatient office visit to a physician or behavioral health provider benefit in the Eligible health services-Specific conditions Mental health treatment and Substance related disorders treatment benefits in your schedule of benefits has been replaced with the following:

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental health telemedicine cognitive therapy consultations by a physician or behavioral health provider</td>
</tr>
</tbody>
</table>

The following language is revised in the Other outpatient services category in the Eligible health services, Specific conditions-Mental health treatment and Substance related disorders-outpatient sections of your schedule of benefits:

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other outpatient services including:</td>
</tr>
<tr>
<td>• Behavioral health services in the home</td>
</tr>
<tr>
<td>• Partial hospitalization treatment</td>
</tr>
<tr>
<td>• Intensive outpatient program</td>
</tr>
</tbody>
</table>

The cost share doesn’t apply to in-network peer counseling support services after you meet your deductible |
The Transplant services facility and non-facility provision in the *Eligible health services-Specific conditions* 
*Transplant services* section of your schedule of benefits is replaced with the following:

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>IOE Facility</th>
<th>Non-IOE Facility and Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant services and</td>
<td>Covered according to the type of benefit and the place where the service is</td>
<td>Covered according to the type of</td>
</tr>
<tr>
<td>supplies</td>
<td>received</td>
<td>benefit and the place where the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>service is received</td>
</tr>
</tbody>
</table>

This amendment makes no other changes to the booklet and schedule of benefits.

Karen S. Lynch  
President  
Aetna Life Insurance Company  
(A Stock Company)

Amendment  
Issue Date December 20, 2019