UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No.: 8:20-cv-03010

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and THE SCHOOL BOARD OF PINELLAS COUNTY,

Defendants.

DEFENDANT AETNA LIFE INSURANCE COMPANY'S
NOTICE OF REMOVAL

PLEASE TAKE NOTICE that Defendant Aetna Life Insurance Company ("Aetna") hereby removes this case from the Circuit Court of the Sixth Judicial Circuit in and for Pinellas County, Florida, to the United States District Court for the Middle District of Florida, Tampa Division.

In support of this Notice of Removal, Aetna states the following:

I. NATURE OF THE REMOVED CASE

1. Plaintiff Scott Lake ("Lake") filed this civil action against Aetna and the School Board of Pinellas County (the "School Board") (collectively, "Defendants") on October 30, 2020, in the Circuit Court of the Sixth Judicial Circuit in and for Pinellas County, Florida, Case No. 20-005171-CI (the "State Court Action").

2. Plaintiff asserts claims in the State Court Action on behalf of himself and a nationwide class of alleged similarly situated individuals. *See generally* Class Action Complaint, *Lake v. Aetna Life Ins. Co. et al.*, No. 20-005171-CI (Fla. Cir. Ct. Oct. 30, 2020) (attached hereto as Exhibit A) ("Compl."). He alleges that his wife is "an Aetna policyholder with self-funded insurance plan through her employer, the School Board and [he] is covered as a defendant under that policy." Compl. ¶ 8. He further alleges Defendants wrongfully denied coverage under the plan for a treatment called Proton Beam Radiation Therapy ("PBRT"). *Id.* ¶ 9. He alleges the treatment was wrongfully denied as an "experimental or investigational" cancer treatment under Aetna's generally applicable policy, referred to as the "PBRT Clinical Policy Bulletin." *Id.* ¶¶ 35–38.

3. Plaintiff purports to represent a nationwide class and two subclasses.[1] The Complaint defines the "Nationwide Class" as:

> All participants or beneficiaries in non-ERISA plans underwritten or administered by Aetna Life Insurance Company, who, citing the application of the PBRT Clinical Policy Bulletin, were denied health insurance coverage for Proton Beam Radiation Therapy to treat their cancer, on grounds that included the assertion that it was "experimental or investigational" or not "medically necessary." The Nationwide Class includes both persons whose post-service claims for reimbursement were denied and persons whose pre-service requests for authorization were denied.

Id. ¶ 68.

4. The "Florida Subclass" is defined as:

> All participants or beneficiaries in non-ERISA Plans underwritten or administered by Aetna Life Insurance

[1] Aetna relies upon Plaintiff's allegations regarding the nature of the putative classes solely for purposes of asserting jurisdiction under CAFA.

> Company under Florida law who, citing the application of the PBRT Clinical Policy Bulletin, were denied health insurance coverage for Proton Beam Radiation Therapy to treat their cancer, on grounds that included the assertion that it was "experimental or investigational" or not "medically necessary." The Florida Subclass includes both persons whose post-service claims for reimbursement were denied and persons whose pre-service requests for authorization were denied.

Id. ¶ 69.

5. Finally, the "Pinellas County Subclass" is defined as:

> All participants or beneficiaries in non-ERISA plans underwritten or administered by Aetna Life Insurance Company for the School Board of Pinellas County, who citing the application of the PBRT Clinical Policy Bulletin, were denied health insurance coverage for Proton Beam Radiation Therapy by the School Board to treat their cancer, on grounds that included the assertion that it was "experimental or investigational" or not "medically necessary." The Pinellas County Subclass includes both persons whose post-service claims for reimbursement were denied and persons whose pre-service requests for authorization were denied.

Id. ¶ 70.

6. The Complaint asserts unjust enrichment claims against Aetna on behalf of the putative Nationwide Class (Count I) and the putative Florida Subclass (Count III) and a claim for declaratory and injunctive relief under Fla. Stat. § 86.011 on behalf of the putative Florida Subclass (Count IV). The Complaint also asserts a claim against the School Board for breach of the implied covenant of good faith and fair dealing on behalf of the putative Pinellas County Subclass (Count II).

II. THIS COURT HAS ORIGINAL JURISDICTION UNDER CAFA.

7. This Court has original jurisdiction over the State Court Action under the Class Action Fairness Act of 2005 ("CAFA"), 28 U.S.C. § 1332(d), and its removal is permitted under 28 U.S.C. §§ 1441(a) and 1453. The State Court Action is a "class action" as defined in CAFA because it was filed under Florida Rule of Civil Procedure 1.220, which is a "rule of judicial procedure authorizing an action to be brought by 1 or more representative persons as a class action." 28 U.S.C. § 1332(d)(1)(B).

8. "CAFA permits the removal of class actions to federal court where the putative class action includes 100 or more members, at least one plaintiff is diverse from one defendant, and the aggregate amount in controversy exceeds $5 million." *Anderson v. Wilco Life Ins. Co.*, 943 F.3d 917, 924 (11th Cir. 2019) (citing 28 U.S.C. §§ 1332(d), 1453). "Unlike in ordinary cases, there is *no presumption against removal* in CAFA cases." *Anderson*, 943 F.3d at 925 (emphasis added). CAFA's "'provisions should be read broadly, with a *strong preference* that interstate class actions should be heard in a federal court if properly removed by any defendant.'"[2] *Dart Cherokee Basin Operating Co., LLC v. Owens*, 574 U.S. 81, 89 (2014) (quoting S. Rep. No. 109-14, p. 43 (2005)) (emphasis added). "While a court may decide that some of a plaintiff's claims lack merit in the context of a motion to dismiss, such considerations are inappropriate as part of a jurisdictional analysis." *McDaniel v. Fifth Third Bank*, 568 F. App'x 729, 731 (11th Cir. 2014) (holding that district court erred when it refused to consider the amount of damages

[2] This presumption in favor of exercising federal jurisdiction differs from the approach in non-CAFA cases, where courts "are encouraged to resolve all doubts about jurisdiction in favor of remand to state court." *Garcia v. Wal-Mart Stores E., L.P.*, No. 6:14-cv-255-Orl-36TBS, 2014 WL 1333208, at *3 (M.D. Fla. Apr. 3, 2014).

flowing from plaintiff's fraud claims based on its determination that those claims failed as a matter of law).

A. Minimal diversity of citizenship is satisfied.

9. This is a controversy between citizens of different states, which satisfies the minimal diversity requirement of CAFA. 28 U.S.C. § 1332(d)(2)(A).

10. The Court may look to a notice of removal and any documents attached thereto for purposes of determining diversity in a removed action. *Pretka v. Kolter City Plaza II, Inc.*, 608 F.3d 744, 752 (11th Cir. 2010); *see also Roe v. Michelin N. Am., Inc.*, 613 F.3d 1058 (11th Cir. 2010).

11. The Complaint alleges that the putative class representative is a citizen of a state different from one of the defendants. Plaintiff alleges that he "is a citizen of Florida who resides in Pinellas County, Florida." Compl. ¶ 7. Plaintiff further alleges that "Defendant Aetna is a Connecticut corporation with its principal place of business in Hartford, Connecticut." *Id.* ¶ 9.

12. Aetna is a citizen of Connecticut because it is incorporated and maintains its principal place of business in that state. Because Plaintiff alleges he is a citizen of Florida, the minimal diversity required under CAFA exists between at least one proposed class member and one defendant. 28 U.S.C. § 1332(d)(2).

B. The amount-in-controversy requirement is satisfied.

13. This case satisfies CAFA's amount-in-controversy requirement because the aggregated potential value of the putative class members' claims exceeds $5 million, exclusive of interest and costs. 28 U.S.C. §§ 1332(d)(2), (6).

14. "The amount in controversy is not proof of the amount the plaintiff will recover. Rather, it is an estimate of the amount that will be put at issue in the course of the litigation." *Pretka*, 608 F.3d at 751 (quotation omitted). It is well established in the Eleventh Circuit that the amount-in-controversy requirement is satisfied when "it is facially apparent from the complaint that the amount in controversy exceeds the jurisdictional requirement.'" *Id.* at 754 (quoting *Williams v. Best Buy Co., Inc.*, 269 F.3d 1316, 1319 (11th Cir. 2010)).[3] In addition to relying on the factual allegations in the Complaint, a removing defendant may rely on "reasonable deductions, reasonable inferences, or other reasonable extrapolations" of the relief requested by the plaintiff in alleging that the requirement is satisfied. *Id.* "Just as [the court] generally accept[s] the plaintiff's good-faith allegations of the amount in controversy to establish diversity jurisdiction, 'when a defendant seeks federal-court adjudication, the defendant's amount-in-controversy allegation should be accepted when not contested by the plaintiff or questioned by the court.'" *Roppo v. Travelers Commercial Ins. Co.*, 869 F.3d 568, 579 (7th Cir. 2017) (quoting *Dart Cherokee*, 574 U.S. at 82) (footnote omitted). In considering these allegations, the court must "aggregate the claims of individual class members and consider the monetary value that would flow to the entire class if [injunctive or] declaratory relief were granted." *Anderson*, 943 F.3d at 925 (quoting *S. Fla. Wellness, Inc. v. Allstate Ins. Co.*, 745 F.3d 1312, 1316 (11th Cir. 2014)). "Once the proponent of CAFA jurisdiction

[3] *See also Roppo v. Travelers Commercial Ins. Co.*, 869 F.3d 568, 579 (7th Cir. 2017) (stating that amount can be calculated by reference to, *inter alia*, "the complaint's allegations" and "the plaintiff's informal estimates" (quotation omitted)); *In re Whole Foods Mkt., Inc., Greek Yogurt Mktg. & Sales Practices Litig.*, No. A-14-MC-2588-SS, 2015 WL 5737692, at *5 (W.D. Tex. Sept. 30, 2015) (discussing "long lines of precedent in both the Eighth and Eleventh Circuits permitting removing defendants to rely on the state court complaints alone to establish the jurisdictional minimums, without resort to extrinsic evidence").

has explained plausibly how more than $5 million is at stake, federal jurisdiction attaches *unless it is legally impossible* for the plaintiff to recover that much." McLaughlin on Class Actions § 12:6 (16th ed.) (emphasis added).

15. Plaintiff purports to represent a nationwide class of individuals covered by non-ERISA Aetna plans who were denied coverage for PBRT based on the PBRT Clinical Policy Bulletin. Compl. ¶ 68. Plaintiff alleges that he "personally paid over $78,000 for [PBRT] treatment out-of-pocket." *Id.* ¶ 66. He also alleges that "PBRT has become so widespread that at a minimum, requests numbering in the hundreds, if not thousands, must have been submitted to and denied by Aetna for coverage of this therapy." *Id.* ¶ 75. He seeks a damages award on behalf of a nationwide class. *Id.* ¶ 94. He also seeks declaratory relief, injunctive relief, and attorneys' fees. *Id.* at 28 (Prayer for Relief ¶¶ B, H). His request for equitable relief includes "disgorgement and surcharges." *Id.* (Prayer for Relief ¶ B). He also seeks an order directing Aetna "to reprocess" claims "without application of the PBRT Clinical Policy Bulletin" as well as an order directing Aetna "to create a common fund out of which it will make payment, with interest, of any unpaid benefits" to Plaintiff and putative class members. *Id.* (Prayer for Relief ¶¶ D, F). In essence, Plaintiff requests full coverage and/or reimbursement for PBRT on behalf of himself and any non-ERISA Aetna insured, nationwide, who was previously denied coverage for the treatment.

16. It is apparent from the face of the Complaint that the aggregate value of the relief requested exceeds $5 million. If one infers that the purported class members are each seeking similar amounts as Plaintiff pleaded (*i.e.*, approximately $78,000), and that the putative class consists of "hundreds, if not thousands" of members as pleaded, it is

reasonable to extrapolate that the relief requested exceeds the $5 million threshold amount for CAFA jurisdiction. *Pretka*, 608 F.3d at 754 (stating that the jurisdictional threshold is satisfied based on "reasonable deductions, reasonable inferences, or other reasonable extrapolations" of the relief requested by the plaintiff); *see also Todorovich v. Accrediting Bureau of Health Educ. Schs., Inc.*, No. 17-20744-CIV, 2017 WL 7726729, at *2 (S.D. Fla. Apr. 25, 2017) (finding jurisdictional threshold satisfied where plaintiff acknowledged her individual claim totaled $21,975.44 and sought to represent a class of at least 400 people, thus establishing an amount in controversy of more than $8 million).

17. Thus, the aggregate amount in controversy exceeds the jurisdictional threshold, and the amount-in-controversy requirement of CAFA has been satisfied.[4]

C. Venue is proper in this district and division and the other statutory requirements for removal have been satisfied.

18. Venue is proper in the United States District Court for the Middle District of Florida, Tampa Division under 28 U.S.C. § 1441(a) because the Circuit Court for the Sixth Judicial Circuit in and for Pinellas County, Florida is within that federal district and division. The Middle District of Florida, Tampa Division, encompasses Pinellas County, Florida, where the State Court Action was filed. 28 U.S.C. § 89(b).

[4] In addition, the exception to CAFA jurisdiction for class actions against state actors does not apply because not all defendants are state actors. 28 U.S.C. § 1332(d)(5)(A); *see also Woods v. Standard Ins. Co.*, 771 F.3d 1257, 1263 (10th Cir. 2014) (concluding that there is "no doubt Congress intended the state action provision to preclude CAFA jurisdiction only when all of the primary defendants are states, state officials, or state entities"); *Frazier v. Pioneer Ams. LLC*, 455 F.3d 542, 546 (5th Cir. 2006) (rejecting view that remand is proper where one primary defendant is indisputably a state entity and concluding that the plain language of "§ 1332(d)(5)(A) is clear—all primary defendants must be states" for the provision to apply). It is beyond dispute that the School Board is a state entity and Aetna is a private entity. Separately, the exemption for classes of "less than 100," 28 U.S.C. § 1332(d)(5)(B), does not apply because Plaintiff alleges a nationwide class consisting of "hundreds, if not thousands" of class members, (Compl. ¶ 75).

19. This Notice of Removal was timely filed under 28 U.S.C. §§ 1446(b) and 1453(b) because Aetna was served with the summons and a copy of the Complaint on November 18, 2020 and is filing this Notice of Removal within thirty (30) days of service.

20. A copy of this Notice of Removal is being filed with the Clerk of the Circuit Court of the Sixth Judicial Circuit in and for Pinellas County, Florida, as provided by law. Aetna will provide written notice of the filing of this Notice of Removal to Plaintiff, as required by 28 U.S.C. § 1446(d), by service on counsel. A completed Civil Cover Sheet accompanies this Notice of Removal.

21. Copies of all process, pleadings, orders and other papers of every kind served upon Defendants or on file in the State Court Action are attached hereto as: Exhibit A (the Complaint); and Exhibit B (all other filings), as required by 28 U.S.C. § 1446(a).

⁂

WHEREFORE, Aetna respectfully requests that (1) the State Court Action be removed to this Court, (2) this Court exercise its subject matter jurisdiction over this action, and (3) the Court grant such other and further relief as it deems just and proper.

Dated: December 17, 2020

Respectfully submitted,

/s/ *Ardith Bronson*

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CERTIFICATE OF SERVICE

I hereby certify that on the 17th day of December 2020, I electronically filed the foregoing document via CM/ECF, which caused a true and correct copy to be served electronically upon all entitled parties.

/s/ *Ardith Bronson*
Ardith Bronson, Esq.

EXHIBIT A

IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT IN AND FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

Case No. _____

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

CLASS ACTION COMPLAINT

Plaintiff Scott Lake ("Plaintiff"), individually and on behalf of all others similarly situated, brings this Class Action Complaint against Defendants Aetna Life Insurance Company ("Aetna") and The School Board of Pinellas County (the "School Board"), pursuant to Rule 1.220 of the Florida Rules of Civil Procedure, and alleges as follows:

INTRODUCTION

1) This is a class action on behalf of beneficiaries of non-ERISA plans administered by Aetna who were denied Proton Beam Radiation Therapy ("PBRT") because of Defendants' uniform application of Aetna's unlawful medical policy to deny as "experimental or investigational" such treatment for cancer, despite PBRT

being recognized for decades by the medical community as an established, medically appropriate treatment for cancer.

2) Instead of acting solely in the interests of the participants and beneficiaries of its health insurance plans, upon information and belief, Aetna and the School Board denied coverage for PBRT to treat cancer because, on average, PBRT is more expensive than traditional Intensity Modulated Radiotherapy ("IMRT") or other treatments.

3) In denying coverage, Aetna and the School Board follow Aetna's Clinical Policy Bulletin No. 270 ("Proton Beam, Neutron Beam, and Carbon Ion Radiotherapy"), which was initially created in 1998 and reviewed most recently on July 29, 2019, (the "PBRT Clinical Policy Bulletin"). While Aetna's PBRT Clinical Policy Bulletin considers PBRT "medically necessary" for persons 21 years old or younger for all types of cancer, it mandates the denial of coverage for PBRT as "experimental or investigational" to treat most cancers on patients over 21 years old.

4) By promulgating and applying its PBRT Clinical Policy Bulletin, Aetna has sacrificed the interests of insureds like Mr. Lake and Class members to artificially decrease the number and value of claims it is required to pay from its own assets, specifically with respect to self-funded plans with stop-loss provisions requiring Aetna to cover benefits above a certain threshold and with respect to fully-insured plans requiring Aetna to pay for all benefits from its own assets.

5) Aetna also profits through the increased interest generated by the School Board funded account when the more expensive PBRT treatment is denied.

6) By applying Aetna's PBRT Clinical Policy Bulletin, the School Board has sacrificed the interests of insureds like Mr. Lake and Class members to artificially decrease the number and value of claims it is required to pay from its assets.

THE PARTIES

7) Plaintiff Scott Lake is a citizen of Florida who resides in Pinellas County, Florida, and is otherwise *sui juris*.

8) Mr. Lake's wife, Amy Jo Lake, is an Aetna policyholder with a self-funded insurance plan through her employer, the School Board and Mr. Lake is covered as a dependent under that policy and therefore is a party to the contract or third-party beneficiary of the contract.

9) Defendant Aetna is a Connecticut corporation with its principal place of business in Hartford, Connecticut. Aetna is a global health care benefits company, which, along with its wholly owned and controlled subsidiaries, offers, insures, underwrites, and administers health benefits plans, including Plaintiff's health benefits plan, as detailed herein. Aetna offers, insures, underwrites, and administers such health benefits plans for consumers nationwide, including within Pinellas County.

10) Defendant the School Board is an agency of a political subdivision organized under the laws of the State of Florida and has its principal place of business in Pinellas County, Florida.

JURISDICTION AND VENUE

11) This Court has subject matter jurisdiction pursuant to Florida Statute §§ 26.012 and 86.011. The amount in controversy exceeds $30,000.00 exclusive of interest, costs, and attorney's fees.

12) This Court has personal jurisdiction over Aetna pursuant to § Fla. Stat. 48.193(1) because Aetna has operated, conducted, engaged in, and carried on a business in Florida and has an office in Florida.

13) This Court has personal jurisdiction over the School Board because it is an agency of a political subdivision of the State of Florida whose principal place of operation is in Pinellas County, Florida.

14) Venue is proper in this Court pursuant to Fla. Stat. §§ 47.011 and 47.021 because the cause of action accrued in Pinellas County and Aetna and the School Board reside in different counties, and as such, venue may be brought in any county in which any Defendant resides. Venue is proper because the School Board resides in Pinellas County as its principal place of business is in the same county.

FACTUAL ALLEGATIONS

A. Aetna Issues and Administers non-ERISA Plans in Florida.

15) Aetna underwrites and administers health benefit plans in Florida that are exempt from ERISA, including individual commercial plans, commercial Exchange plans, Medicare Advantage plans, Medicaid plans, governmental plans, church plans, and voluntary plans ("non-ERISA plans"). In particular, Aetna interprets and applies non-ERISA plans' terms, makes coverage and benefit

decisions under the non-ERISA plans, and provides payment under the non-ERISA plans to participants/beneficiaries and their providers.

16) Aetna administers either self-funded plans or fully insured plans. With respect to fully insured plans, Aetna both, administers the plan by making all benefit determinations, and pays the benefits out of its own assets.

17) When processing benefits for a self-funded plan, Aetna makes certain benefit determinations and authorizes benefit checks to be issued out of bank accounts that Aetna controls. Periodically, Aetna will notify the sponsors of the self-funded plans of the need to replenish their accounts so that benefits can be paid. The underlying plan sponsor or employer through which the insurance is provided is ultimately responsible for reimbursing Aetna for the benefit payments.

18) Aetna's self-funded plans often include stop-loss provisions, which require Aetna to cover and fund benefits above a certain threshold from its own assets.

19) There are no differences in the manner in which Aetna approves or denies PBRT across all non-ERISA plans: Aetna relies upon the PBRT Clinical Policy Bulletin to approve or deny PBRT across all non-ERISA plans.

B. The School Board of Pinellas County's Contract with Aetna.

20) The School Board contracted with Aetna to establish a self-funded employee benefit plan. Upon information and belief, Aetna uses the same standard contract for all self-funded plans with employers. Pursuant to the contract, the School Board funds an Aetna account for the purpose of paying out claim benefits to

the insured.

21) Under the School Board and Aetna's standard Agreement ("Agreement"), Aetna determines whether a claim for benefits is consistent with terms of the plan, processes and adjudicates each claim, and makes determinations of the amounts due and payable pursuant to the plan.

22) Aetna then prepares, issues, and signs checks from the Aetna account funded by the School Board for paying the claims.

23) The Agreement provides that Aetna may keep any interest generated from the account (after paying bank fees) up to the LIBOR rate plus two percent. Therefore, it is in Aetna's interest to deny claims for the more expensive PBRT treatment and thus keep more funds in the account and increase its own profits through the interest generated by the account.

24) Under the Agreement, when a participant's claim for benefits is denied, Aetna is the decisionmaker and "appropriate named fiduciary" for the first two levels of appeal. For these two levels of appeal, Aetna has the discretionary authority for the determination and evaluation of facts and evidence presented in support of the claims and appeals, and to construe the terms of the plan.

25) Under the Agreement, if Aetna upholds a denial, Aetna has the sole authority to determine if the appeal is eligible for an External Review Organization ("ERO"). If the appeal is not eligible for ERO or the ERO upholds the denial, then the member has a right to appeal the decision to the School Board.

26) The School Board holds ultimate discretionary authority over the final

appeal decision concerning a claim denial.

C. Proton Beam Radiation Therapy.

27) PBRT is a procedure that uses protons to deliver a curative radiation dose to a tumor, while reducing radiation doses to healthy tissues and organs, which results in fewer complications and side effects than traditional IMRT.

28) With PBRT, protons deposit their energy over a very small area called the "Bragg peak." The Bragg peak can be used to target high doses of proton beams to a tumor, while doing less damage to normal tissues in front of and behind the tumor. The concentration of proton beams enables patients to tolerate higher total doses of radiotherapy compared with photons, which are used for traditional IMRT.

29) There is overwhelming evidence that PBRT is safe and effective and is a generally accepted standard of medical practice for the treatment of cancer within the medical community.

30) PBRT has been well-accepted for over 30 years. The Food and Drug Administration ("FDA") approved PBRT in 1988 with the following specific statement of indications for intended use: "The [Proton Therapy System] is a medical device designed to produce and deliver proton beam for the treatment of patients with localized tumors and other conditions susceptible to treatment by radiation."

31) The National Association for Proton Therapy, the Alliance for Proton Therapy and other nationally recognized medical organizations, and numerous meticulous peer-reviewed studies have validated the safety and effectiveness of PBRT.

32) Additionally, many respected cancer facilities and providers, including Baptist Hospital's Miami Cancer Institute, MD Anderson Cancer Center, University of Florida, Harvard Medical School/Massachusetts General Hospital, Loma Linda University Medical Center University of Maryland, Northwestern University, Mayo Clinic, Emory University, Case Western Reserve University, Washington University in St. Louis, University of Washington, New York Proton Center, and the Texas Center for Proton Therapy, recommend and use PBRT on a regular basis.

33) Other insurers, including Medicare, cover PBRT as a safe and effective treatment for cancer, that is not "experimental."

D. Aetna's PBRT Clinical Policy Bulletin.

34) Aetna drafted and implemented the PBRT Clinical Policy Bulletin, which was most recently reviewed on July 29, 2019, based on outdated medical evidence and ignoring accepted medical peer-reviewed evidence that it is safe and effective for the treatment of cancer.

35) The PBRT Clinical Policy provides that:

> Aetna considers proton beam radiotherapy not medically necessary for individuals with localized prostate cancer because it has not been proven to be more effective than other radiotherapy modalities for this indication.[1]

36) Aetna also considers PBRT "experimental and investigational for all other indications," including cancers in "adults (over age 21) . . . because its effectiveness for these indications has not been established."

[1] The PBRT Clinical Policy is available at http://www.aetna.com/cpb/medical/data/200_299/0270.html.

37) On the other hand, Aetna considers PBRT "medically necessary" to treat all "[m]alignancies in children (21 years of age and younger)," as well as certain listed types of tumors.

38) Aetna's PBRT Clinical Policy Bulletin does not consider PBRT "experimental and investigational" when treating teenagers or children (21 years of age and younger) and approves PBRT for these patients.

39) This distinction is completely arbitrary as there are no medical studies that support a conclusion that PBRT would be a proven, safe, and effective treatment for the same cancer in one age group, but not the other.

40) As part of their prior authorization review and adjudication of members' claims, Aetna and the School Board employ the PBRT Clinical Policy Bulletin to deny claims for coverage of PBRT as "experimental or investigational" or not "medically necessary" without ever engaging in any reasonable review of clinical records prior to rendering the determination of coverage.

41) There are no material differences in Defendants' use of the PBRT Clinical Policy Bulletin to deny PBRT.[2] Further, there is no material differences in Aetna's use of the PBRT Clinical Policy Bulletin for all non-ERISA plans. All patients are denied treatment based solely on the basis of PBRT being "experimental or investigational" or not "medically necessary" and Defendants never consider the type of cancer or any individual circumstances of the patient.

42) In other words, Aetna and the School Board cite the PBRT Clinical

[2] Other than for patients under 21 years of age and for particular types of tumors.

Policy Bulletin to categorically deny prior authorization requests and claims for reimbursement for PBRT for most patients and most cancers on the grounds that PBRT is not medically necessary or experimental without regard to the recommendation and assessment of the patients' own oncologist or medical records and without regard to PBRT's widespread acceptance and medical literature and other overwhelming evidence showing that PBRT is safe and effective.

INDIVIDUAL ALLEGATIONS

A. Plaintiff's Plan.

43) Plaintiff is a party or a third-party beneficiary of his wife's contract with the School Board to obtain health insurance benefits.

44) Plaintiff is a beneficiary of an Open Access Aetna Select HRA Plan prepared for the School Board (the "Plan").

45) The School Board is the Plan Sponsor.

46) The Summary Plan Description is a plan document governing Plaintiff's insurance that details the terms and conditions of the Plan.

47) Under the Summary Plan Description, "medical necessity is a requirement for [a beneficiary] to receive a covered benefit under this plan."

48) The Summary Plan Description defines "Medically necessary" as:

> Health care services that a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

49) In addition, the Summary Plan Description includes a list of "General exclusions," which are deemed to be services that are not covered under the Plan. One such exclusion is for "[e]xperimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs)."

50) "Experimental or Investigational" is defined as:

A drug, device, procedure, or treatment that is found to be experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved
- The needed approval by the FDA has not been given for marketing

- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes

- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services

- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

51) Radiation therapy is a procedure, and therefore, is not subject to FDA regulation.

52) The accelerators and other equipment used to generate and deliver PBRT are regulated by the FDA. On February 22, 1988, the FDA approved the Proton Therapy System, and designated it as a Class II Device for radiological treatment. This classification was codified at 21 C.F.R. § 892.5050 and describes the Proton Therapy System as a "device that produces by acceleration high energy charged particles (e.g., electrons and protons) intended for use in radiation therapy." Thus, at least as of February 22, 1988, PBRT no longer fit within the E/I Exclusion to the Employer Plan.

53) PBRT has long been recognized as an established, medically appropriate treatment for the treatment of cancer, including prostate cancer.

B. Aetna's Denial of Coverage to Plaintiff.

54) Mr. Lake was diagnosed with prostate cancer in May 2019. Mr. Lake's radiation oncologist at the University of Florida Health Proton Institute ("UF Health"), Dr. Romaine Nichols, recommended that Mr. Lake undergo PBRT as the

most effective treatment option for him because, among other things, the likelihood of achieving a better outcome was greater with PBRT.

55) On August 29, 2019, Aetna denied Mr. Lake's request for pre-authorization of PBRT because "[t]he plan does not cover experimental or investigational services except under certain conditions. Please see the reference to experimental or investigational services listed in the Exclusions section of the benefit plan document."

56) To reach that decision, Aetna stated: "We reviewed information received about your condition and circumstances. We used the Clinical Policy Bulletin (CPB): Proton Beam and Neutron Beam Radiotherapy. Based on CPB criteria and the information we have, we are denying coverage for proton beam radiotherapy. Medical studies do not prove that this procedure is better than and as safe as other radiation treatment for prostate cancer. The American Society for Radiation Oncology (ASTRO, 2013) stated that there is no clear evidence that proton beam therapy for prostate cancer offers any clinical advantage over other forms of definitive radiation therapy."

57) UF Health submitted two internal appeals on Mr. Lake's behalf, asking that Aetna reconsider its decision to deny coverage or payment for PBRT. Dr. Nichols explained that "[i]t is especially important to minimize toxicity for a patient such as Mr. Lake who should have an excellent chance of cure and survival. Serious toxicity from treatment would impact his quality of life as well as his health care costs in the future." Dr. Nichols concluded that "[a]fter careful review of the patient's

history and medical records, proton therapy was deemed to be medically appropriate, therapeutically optimal, and medically necessary treatment."

58) Mr. Lake's first appeal included 91 pages of written materials and was denied in a little over a week.

59) Aetna received the second appeal on September 30, 2019, and upheld its decision to deny coverage the next day, on October 1, 2019.

60) Notably, in denying coverage, Aetna failed to discuss or even acknowledge the information provided by Dr. Nichols supporting PBRT, including the many studies verifying its safety and efficacy. Thus, Aetna provided Mr. Lake with no basis for its negative coverage determination aside from its reliance—to the exclusion of all contrary evidence—on Aetna's PBRT Clinical Policy Bulletin.

61) Mr. Lake then formally requested an external review of Aetna's decision to deny his request for PBRT to treat his prostate cancer.

62) On November 4, 2019, Mr. Lake received a letter from Aetna indicating that the "independent" review organization, AllMed Healthcare Management, agreed with Aetna's decision to deny coverage for PBRT to treat Mr. Lake's prostate cancer.

C. The School Board's Denial of Coverage to Plaintiff.

63) Though not obligated to do so, Mr. Lake made a final appeal to the School Board, who has "ultimate responsibility for the final review of claims under [Plaintiff's] health benefits plan."

64) On November 5, 2019, Mr. Lake submitted a detailed letter to the

School Board seeking to appeal Aetna's decision. Mr. Lake submitted substantial evidence to the School Board that PBRT for prostate cancer is neither experimental nor investigational and that PBRT for prostate cancer is at least as effective as other established technology. Mr. Lake submitted several peer-reviewed articles, other insurance policies regarding PBRT, and Medicare's PBRT policy.

65) On November 19, 2019, the School Board upheld Aetna and Allmed's previous denial decisions for PBRT services. The School Board reasoned that the PBRT services were not covered under Aetna's Clinical Policy Bulletin because the procedures are "experimental and investigational." The School Board did not give any other reason for denial. The School failed to address or refute any of the evidence provided by Mr. Lake.

D. Plaintiff Pursued the PBRT Treatment.

66) Following the denials, Mr. Lake decided to follow the recommendation of his radiation oncologist and received PBRT to treat his prostate cancer, with success. Mr. Lake personally paid over $78,000 for the treatment out-of-pocket. The PBRT was unreimbursed, though some ancillary charges for medical consultations and other services were reimbursed by Aetna.

CLASS ALLEGATIONS

67) Plaintiff brings this class action and seeks to certify and maintain it as a class action under Florida Rules of Civil Procedure 1.220(a), and 1.220(b)(1), or 1.220(b)(2), or 1.220(b)(3).

68) Plaintiff brings claims on his own behalf and on behalf of a "Nationwide

Class," defined as:

> All participants or beneficiaries in non-ERISA plans underwritten or administered by Aetna Life Insurance Company, who, citing the application of the PBRT Clinical Policy Bulletin, were denied health insurance coverage for Proton Beam Radiation Therapy to treat their cancer, on grounds that included the assertion that it was "experimental or investigational" or not "medically necessary." The Nationwide Class includes both persons whose post-service claims for reimbursement were denied and persons whose pre-service requests for authorization were denied.

69) Plaintiff also brings claims on his own behalf and on behalf of a "Florida Subclass," defined as:

> All participants or beneficiaries in non-ERISA Plans underwritten or administered by Aetna Life Insurance Company under Florida law who, citing the application of the PBRT Clinical Policy Bulletin, were denied health insurance coverage for Proton Beam Radiation Therapy to treat their cancer, on grounds that included the assertion that it was "experimental or investigational" or not "medically necessary." The Florida Subclass includes both persons whose post-service claims for reimbursement were denied and persons whose pre-service requests for authorization were denied.

70) Plaintiff also brings claims on his own behalf and on behalf of a "Pinellas County Subclass,"[3] defined as:

> All participants or beneficiaries in non-ERISA plans underwritten or administered by Aetna Life Insurance Company for the School Board of Pinellas County, who citing the application of the PBRT Clinical Policy Bulletin, were denied health insurance coverage for Proton Beam Radiation Therapy by the School Board to treat their cancer, on grounds that included the assertion that it was "experimental or investigational" or not "medically necessary." The Pinellas County Subclass includes both persons whose post-service claims for reimbursement were denied and persons whose pre-service requests for authorization were denied.

[3] The Nationwide Class, the Florida Subclass, and the Pinellas County Subclass are referred to collectively as the "Class."

71) Excluded from the Class are: (a) Defendants, including any entity or division in which Defendants have a controlling interest, as well as their agents, representatives, officers, directors, employees, trustees, and other entities related to, or affiliated with Defendants, (b) Class Counsel, and (c) the Judge to whom this case is assigned and any members of the Judge's staff or immediate family.

72) The definition of "experimental or investigational" services or treatment in Aetna's health insurance policies at all relevant times has been substantially similar to the definition in Plaintiff's Plan, and is interpreted by Aetna as having the same meaning as, comparable exclusions included in the Aetna plans applicable across all plans and to all Class members.

73) The definition of "medically necessary" services or treatment in Aetna's health insurance policies at all relevant times has been substantially similar to the definition in Plaintiff's Plan, and is interpreted by Aetna as having the same meaning as, comparable exclusions included in the Aetna plans applicable across all plans and to all Class members.

A. Numerosity

74) The members of each Class are so numerous that joinder of all members is impractical.

75) While the precise number of members in the Classes is known only to Aetna, Aetna has issued policies providing coverage under tens of thousands of health insurance plans, and PBRT has become so widespread that at a minimum, requests numbering in the hundreds, if not thousands, must have been submitted to

and denied by Aetna for coverage of this therapy.

76) The Classes are ascertainable because their members can be readily identified using Aetna's claims data. PBRT therapy is described with a discrete set of procedure codes under the Current Procedural Terminology ("CPT") promulgated by the American Medical Association. Accordingly, Class members can be readily and objectively ascertained through the use of records maintained by Aetna.

77) Finally, Class members are dispersed geographically throughout the United States, such that joinder of all members is impracticable.

78) Plaintiff anticipates providing appropriate notice to the Classes, once certified, in compliance with Fla. R. Civ. P. 1.220(d), to be approved by the Court after class certification, or pursuant to court order.

B. Predominance of Common Issues

79) This action satisfies the requirements of Fla. R. Civ. P. 1.220(a)(2) and 1.220(b)(3) because questions of law and fact that have common answers predominate over questions affecting only individual Class members. These include, without limitation:

a. Whether PBRT therapy is an "experimental or investigational" service or treatment;

b. Whether the PBRT Clinical Policy Bulletin is based on outdated medical evidence;

c. Whether Aetna categorically applied the PBRT Clinical Policy Bulletin to deny coverage to Class members;

d. Whether the School Board categorically applied the PBRT Clinical Policy Bulletin to deny coverage to Class members;

e. Whether Class members' claim denials were based in whole or in part on the Aetna PBRT Clinical Policy Bulletin;

f. Whether Aetna acted in good faith in creating, developing, revising, and applying the PBRT Clinal Policy Bulletin to deny coverage to Class members;

g. Whether Aetna unjustly benefited from its uniform application of the PBRT Clinical Policy Bulletin; and

h. Whether Class members are entitled to the relief sought if Plaintiff establishes liability.

C. Typicality.

80) Plaintiff's claims are typical of the claims of each of the Class members as all Class members were and are similarly affected and their claims arise from the same wrongful conduct of Aetna and the School Board. Plaintiff is a beneficiary of a non-ERISA Plan administered by Aetna, he submitted a claim for coverage of PBRT for treatment of his cancer, and, like other Class members, Aetna and the School Board denied his claim based on the PBRT Clinical Policy Bulletin and an incomplete research database that both Defendants reference with respect to all requests for coverage of PBRT for treatment of cancer.

D. Adequacy of Representation.

81) Plaintiff will fairly and adequately protect the interests of the Classes.

Plaintiff's interests do not conflict with the interests of the members the Classes. Further, Plaintiff has retained counsel who are competent and experienced in complex class action litigation, and Plaintiff and his counsel intend to prosecute this action vigorously on behalf of the Class members and have the financial resources to do so. Neither Plaintiff nor his counsel has any interest adverse to those of the Class members.

E. Superiority.

82) Certification is appropriate under Fla. R. Civ. P. 1.220(b)(1) because the prosecution of separate actions by Plaintiff or individual Class members would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for Aetna and the School Board or adjudications with respect to individual Class members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests.

83) Certification is appropriate under Fla. R. Civ. P. 1.220(b)(2) because by applying a uniform policy treating PBRT as "experimental," "investigational," "not medically necessary," or "unproven," Aetna and the School Board have acted and refused to act on grounds that apply generally to the Class, thereby requiring the Court's imposition of uniform relief to ensure compatible standards of conduct towards Class members, and making final injunctive relief or corresponding declaratory relief appropriate respecting the proposed Class as a whole.

84) Certification is appropriate under Fla. R. Civ. P. 1.220(b)(3) because a class action is superior to other available methods for the fair and efficient adjudication of this controversy. Questions of law and fact common to the Class members predominate over any questions affecting only individual members.

85) A class action is superior to other available methods for the fair and efficient adjudication of this controversy because joinder of all Class members is impracticable. Further, because the damages suffered by Class members are small relative to the expense and burden of individual litigation, it would be impossible for the members of the Class to redress individually the harm done to them, such that most or all Class members would have no rational economic interest in individually controlling the prosecution of specific actions, and the burden imposed on the judicial system by individual litigation by even a small fraction of the Class would be enormous, making class adjudication the superior alternative.

86) The conduct of this action as a class action presents far fewer management difficulties, far better conserves judicial resources and the parties' resources, and far more effectively protects the rights of each sub-Class member than would piecemeal litigation. Compared to the expense, burdens, inconsistencies, economic infeasibility, and inefficiencies of individualized litigation, the challenges of managing this action as a class action are substantially outweighed by the benefits to the legitimate interests of the parties, the court, and the public of class treatment in this court, making class adjudication superior to other alternatives.

87) Plaintiff is not aware of any obstacles likely to be encountered in the management of this action that would preclude its maintenance as a class action. Rule 1.220 provides the Court with authority and flexibility to maximize the efficiencies and benefits of the class mechanism and reduce management challenges. The Court may, on Plaintiff's motion or on its own determination, utilize the provisions of Rule 1.220(d)(4) to certify any particular claims, issues, or common questions of fact or law for class-wide adjudication or divide the Class into further subclasses.

COUNT I

UNJUST ENRICHMENT
Against Defendant Aetna on Behalf of the Nationwide Class

88) Plaintiff incorporates by reference paragraphs 1 through 87 as if fully stated herein.

89) Plaintiff brings this claim individually and on behalf of the Nationwide Class under the common law of unjust enrichment as there are no true conflicts (case-dispositive differences) among various states' laws of unjust enrichment.

90) Aetna wrongfully denied approval or reimbursement for PBRT, thereby unjustly saving the cost of more expensive, but more effective PBRT treatment in their fully insured plans, where Aetna pays for the benefits out of their own pockets, and in self-funded plans with stop-loss provisions requiring Aetna to cover benefits above a certain threshold.

91) Further, Aetna unjustly benefits from the increased interest generated by the plan account when it denies the PBRT treatment and pays less or no funds

from the account.

92) It is inequitable for Aetna to retain these benefits. Aetna will be unjustly enriched if it is allowed to retain the aforementioned benefits, and each Nationwide Class member is entitled to recover the amount by which Aetna was unjustly enriched at his or her expense.

93) The amount of Aetna's unjust enrichment should be disgorged, in an amount to be proven at trial.

94) Plaintiff, on behalf of himself and the Nationwide Class members, seeks an award against Aetna in the amount by which Aetna has been unjustly enriched at Plaintiff's and the Nationwide Class members' expense, and such other relief as this Court deems just and proper.

COUNT II

BREACH OF IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING
Against Defendant the School Board on Behalf of the Pinellas County Subclass

95) Plaintiff incorporates by reference paragraphs 1 through 87 as if fully stated herein.

96) Plaintiff brings this claim individually and on behalf of all Pinellas County Subclass members.

97) A covenant of good faith and fair dealing is implied in every contract and imposes upon each party a duty of good faith and fair dealing in its performance. Common law calls for substantial compliance with the spirit, not just the letter, of a contract in its performance.

98) Where an agreement affords one party the power to make a discretionary decision without defined standards, the duty to act in good faith limits that party's ability to act capriciously to contravene the reasonable contractual expectations of the other party.

99) Plaintiff contracted for insurance as a party or third-party beneficiary to his wife's insurance agreement with the School Board. *See* the "Aetna Select Medical Plan" attached hereto as **Exhibit A**.[4]

100) Plaintiff and Subclass members' Plan allows the School Board, as the Plan Sponsor, to have ultimate authority over final appeal decisions to claim denials.

101) The School Board has extensive and ultimate discretion to determine whether a treatment is "medically necessary" or "experimental and investigational."

102) The School Board has an obligation to exercise the discretion afforded to it in good faith, and not capriciously or in bad faith. Plaintiff does not seek to vary the express terms of the Plan, but only to ensure that the School Board exercises its discretion in good faith.

103) The School Board breached the implied covenant of good faith and fair dealing in bad faith and in contravention of the parties' reasonable expectations by, among other things,

a) Exercising its discretion to deny Plaintiff's treatment relying exclusively on Aetna's PBRT Clinical Policy Bulletin and Aetna's prior

[4] The Select Medical Plan is one of the two documents forming the contract for insurance. The other document, the "Schedule of Benefits" is in Aetna's possession and Plaintiff will seek its production in discovery.

denials;

b) Failing to review the medical records, medical literature, and other materials that Plaintiff's doctors submitted with his appeals of denial;

c) Exercising its discretion to determine that Plaintiff and the Subclass members' PBRT treatment was not medically necessary and was experimental or investigational despite overwhelming medical evidence to the contrary; and

d) Exercising its discretion to deny Plaintiff's PBRT treatment to increase its own profits and avoid paying for a higher-cost treatment.

104) As a direct, proximate, and legal result of the aforementioned breach of the covenant of good faith and fair dealing, Plaintiff and the Subclass have suffered damages.

COUNT III

UNJUST ENRICHMENT
Against Defendant Aetna on Behalf of the Florida Subclass

105) Plaintiff incorporates by reference paragraphs 1 through 87 as if fully stated herein.

106) Plaintiff brings this claim individually and on behalf of all Florida Subclass members.

107) Aetna wrongfully denied approval or reimbursement for PBRT, thereby unjustly saving the cost of more expensive, but more effective PBRT treatment in their fully insured plans, where Aetna pays for the benefits out of their own pockets,

and in self-funded plans with stop-loss provisions requiring Aetna to cover benefits above a certain threshold.

108) Further, Aetna unjustly benefits from the increased interest generated by the plan account when it denies the PBRT treatment and pays less or no funds from the account

109) It is inequitable for Aetna to retain these benefits. Aetna will be unjustly enriched if it is allowed to retain the aforementioned benefits, and each Florida Subclass member is entitled to recover the amount by which Aetna was unjustly enriched at his or her expense.

110) The amount of Aetna's unjust enrichment should be disgorged, in an amount to be proven at trial.

111) Plaintiff, on behalf of himself and the Florida Subclass members, seeks an award against Aetna in the amount by which Aetna has been unjustly enriched at Plaintiff's and the Subclass members' expense, and such other relief as this Court deems just and proper.

COUNT IV

DECLARATORY AND INJUNCTIVE RELIEF
Against Defendant Aetna on Behalf of the Florida Subclass
(Florida Statute Section 86.011)

112) Plaintiff incorporates by reference paragraphs 1 through 87 as if fully stated herein.

113) Plaintiff brings this claim individually and on behalf of the Florida Subclass.

114) As an administrator in either self-funded or fully insured plans, Aetna makes benefit determinations as to whether services provided to its members are medically necessary, experimental or investigational, and covered under the respective plans.

115) An actual, immediate controversy exists among the parties regarding whether coverage for PBRT for the treatment of cancer is afforded under the Plan and other non-ERISA plans administered by Aetna.

116) Plaintiff and Florida Subclass members and Aetna are in dispute as to the parties' respective rights, obligations, and duties pursuant to the terms and conditions of the Plan and other non-ERISA plans administered by Aetna, and the creation, development, and application of the PBRT Clinical Policy Bulletin to categorically deny coverage for PBRT to treat cancer.

117) A good faith dispute exists as to the issues set out in paragraph 79 of this Complaint.

118) Plaintiff and Florida Subclass members have a substantial interest at stake in the resolution of this controversy, namely, obtaining the reprocessing of their claims without application of the PBRT Clinical Policy Bulletin, as well as any other applicable supplemental relief.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment in his favor and against Defendants Aetna and the School Board as follows:

A. Certifying the Class, as set forth in this Complaint, and appointing

Plaintiff as Class Representative and undersigned counsel as Class Counsel;

B. Declaring that Aetna violated the terms of Plaintiff's Plan, and the similar non-ERISA Plans of the other members of the Nationwide Class and the Florida Subclass, and awarding appropriate equitable and supplemental relief including disgorgement and surcharges;

C. Declaring that the School Board violated Plaintiff's Plan, and the plans of the other members of the Pinellas County Subclass, awarding appropriate equitable and supplemental relief including disgorgement and surcharges;

D. Ordering Aetna to reprocess Plaintiff's, Nationwide Class, and Florida Subclass members' claims without application of the PBRT Clinical Policy Bulletin;

E. Ordering the School Board to reprocess Plaintiff's and Pinellas County Subclass members' claims without application of the PBRT Clinical Policy Bulletin;

F. Ordering Aetna to create a common fund out of which it will make payment, with interest, of any unpaid benefits to Plaintiff, Nationwide Class, and Florida Subclass members;

G. Ordering the School Board to create a common fund out of which it will make payment, with interest, of any unpaid benefits to Plaintiff and Pinellas County Subclass members;

H. Awarding Plaintiff disbursements and expenses of this action, including reasonable attorneys' fees, in amounts to be determined by the Court; and

I. Granting such other and further relief as is just and proper.

DEMAND FOR JURY TRIAL

Plaintiff demands a jury trial on all issues so triable.

DATED: October 30, 2020.

Respectfully submitted,

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EXHIBIT A

BENEFIT PLAN

Prepared Exclusively for
The School Board of Pinellas County

Open Access Aetna Select H R A Plan

Also known as: Consumer Directed Health Plan (CDHP + HRA)

What Your Plan Covers and How Benefits are Paid

Aetna Select Medical Plan

Summary Plan Description

Prepared exclusively for:

Employer:	The School Board of Pinellas County
Contract number:	MSA-109718
	Booklet 3
Plan effective date:	January 1, 2019
Plan issue date:	April 19, 2019

Third Party Administrative Services provided by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded health benefit plan for in-network coverage.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

Each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded health benefit plan for in-network coverage.

Table of Contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna** when we are describing administrative services provided by **Aetna** as Third Party Administrator.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**.

What your plan does – covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network coverage for medical, vision and pharmacy benefits.

What your plan doesn't do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described more in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the *Eligible health services under your plan* section. However, some of those health care services and supplies have exclusions. For example, **physician care** is an eligible health service, but **physician care** for cosmetic surgery is never covered. This is an example of an exclusion.

The *What your plan doesn't cover - some eligible health service exclusions* section of this document also provides additional information.

The Plan does not cover any payments that are prohibited by the Federal Office of Foreign Asset Control.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- Generally will pay only when you get care from **providers** in our network of doctors, **hospitals**, and other **providers**.
- You will pay less cost share when you use a **network provider**.

1. **Eligible health services**

   Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

   So what are **eligible health services**? They are health care services that meet these three requirements:

   - They are listed in the *Eligible health services under your plan* section.
   - They are not carved out in the *What your plan doesn't cover – some eligible health service exclusions* section. (We refer to this section as the "exclusions" section.)
   - They are not beyond any limits in the schedule of benefits.

2. **Providers**

   Aetna's network of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your Aetna Navigator® secure member website at www.aetna.com.

   You may choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

   For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

3. **Service area**

   Your plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. There are some exceptions, such as for **emergency services** and urgent care. See the *Who provides the care* section.

4. **Paying for eligible health services– the general requirements**

   There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

   - The **eligible health service** is **medically necessary**, and
   - You get your care from:
     - Your **PCP**, or
     - Another **network provider** after you get a **referral** from your **PCP**, and
   - You or your **provider precertifies** the **eligible health service** when required.

   You will find details on **medical necessity, referral** and **precertification** requirements in the *Medical*

necessity, referral and precertification requirements section. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

5. **Disagreements**
   We know that people sometimes see things differently.

   The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an "external review organization" or ERO for short, will make the final decision for us.

   For more information see the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by logging onto your Aetna Navigator® secure member website at www.aetna.com.

Register for Aetna Navigator®, our secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Aetna Navigator® secure member website at www.aetna.com.

In addition to a member ID card, you will also receive a separate HRA card.

An HRA is an account funded by Pinellas County Schools. You can use these funds to pay for eligible health care expenses for you and your eligible dependents currently enrolled in the plan. Expenses may include deductibles, copays and coinsurance amounts, however dental and vision expenses are excluded. This card can only be used with the CDHP + HRA plan.

HRA Administered by PayFlex	
Individual	$500
Family	$1,000

These amounts are prorated if enrolled on or after January 1st.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

You are eligible for benefits if you are:

- A full-time, regular employee who works at least 30 hours per week.
- A job-sharing employee, or
- A part-time, regular employee in two or more authorized positions who works at least 30 hours per week.

Your insurance coverage is effective the first day of the month following 60 days of employment in an eligible status.

When you can join the plan

As an employee you can enroll yourself you and your dependents if you live or work in the **service area**:

- At the end of any waiting period your Employer requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

Dependent Coverage and Eligibility

You may elect coverage (when available) for your eligible dependents, including:

- **Your legal spouse** as defined by the state of Florida.
- **Your children,** including biological children, stepchildren, legally adopted children, and children for whom you have legal guardianship as shown by court documents naming you as permanent legal guardian.

Medical Coverage for Children

Your eligible children can be covered under a PCS medical, dental, and/or vision plan through the end of the calendar year in which they reach age 26, regardless of marital, financial, or student status. A covered child's spouse is not eligible for coverage.

Please note, as allowed by Florida law, you may cover a grandchild from birth to age 18 months provided your child was covered under your PCS medical plan when your grandchild was born.

- **Handicapped Dependents.** There is no age limitation for an unmarried handicapped dependent child provided the following requirements are met:
  - The dependent must be chiefly dependent upon the employee for support and maintenance, and be incapable of self-support due to mental or physical incapacity, either of which commenced prior to reaching a limiting age.

— The dependent had continuous coverage under a Pinellas County Schools group health insurance plan.
— The employee must submit proof of the handicapped dependent's condition and eligibility to the Risk Management and Insurance Department and the appropriate health plan(s) within 31 days after the end of the year in which the dependent reaches a limiting age.

Adding new dependents

Enrolling a Newborn Child*

You may submit an enrollment application for your newborn child prior to the birth of the child or within 31 days after birth to Pinellas County Schools, Risk Management and Insurance Department.
Do not call Aetna.

Should you submit an enrollment application to Pinellas County Schools between 31and 60 days after your newborn child's birth, your medical plan may require that any additional prepayment fees (premium) be remitted for the period beginning at the date of birth through the date of enrollment. When these requirements are met, the effective date of coverage is the date of birth. If you do not meet these requirements, you may enroll your child during the next Annual Enrollment period for the next plan year.

An adopted child*
To enroll your adopted child covered, your Employer must receive your completed enrollment information within 31 days after the adoption or placement in the home for adoption. If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
*Coverage will begin the first of the month following the date of the birth or placement in the home and employer receives the completed documentation.

Special times you and your dependents can join the plan

You can enroll or add dependents within 31 days of a HIPAA qualifying life event and other events designated by the employer. Life events may include but are not limited to: marriage, birth of a child, divorce, loss or gain of employer group or state sponsored coverage.

Effective date of coverage

Your coverage begins on the date your employer tells us. This will be the effective date on the enrollment information sent to us to enroll you and your eligible dependents in the plan.

Claims will not be paid under any health benefits for expenses incurred in connection with any hospital stay that began before the date you or your dependents became covered.

Medical necessity requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services under your plan* and *exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirements are met. They are:

- The **eligible health service** is **medically necessary**.

This section addresses the **medical necessity** requirements.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary**, **medical necessity**". That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a **pharmacy**. The following **precertification** information applies to these **prescription drugs**:

For certain drugs, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

There is another type **of precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can obtain the most up-to-date information about **step therapy prescription drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com. Your doctor can find additional details about the **step therapy prescription drugs** in our clinical policy bulletins.

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not covered or for which health care services are denied through **precertification and/or step therapy**. You or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exclusions in the *exclusions* section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

   These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender- specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. 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:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Preventive care immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician, PCP,** obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears and routine chlamydia screening tests. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits;
  - Tobacco cessation prescription and over-the-counter drugs
    - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a **network provider** who is an OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's**, **PCP's,** OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *exclusions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician**, **PCP**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

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

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon who you go to for a second opinion before the **surgery**

Important note:
Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician** services and not for a separate fee for facilities.

Alternatives to physician office visits

Walk-in clinic

Eligible health services include health care services provided in **walk-in clinics** for:

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital.**
- Operating and recovery rooms.
- Intensive or special care units of a **hospital.**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery center** or a **hospital's** outpatient department.

Important note: Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician or PCP** services and not for a separate fee for facilities.

Home health care

Eligible health services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care**.

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

As it applies to in-network coverage, you are covered for follow-up care only when your **physician or PCP** provides or coordinates it.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your **physician or PCP** but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *exclusion- Emergency services and urgent care* sections for specific plan details.

In case of an urgent condition

Urgent condition within the service area

If you need care for an **urgent condition** while within the **service area**, you should first seek care through your, **physician.** If your **physician** is not reasonably available to provide services, you may access urgent care from an **urgent care facility** within the **service area**.

Urgent condition outside the service area

You are covered for urgent care obtained from a facility outside of the **service area** if you are temporarily absent from the **service area** and getting the health care service cannot be delayed until you return to the **service area**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition,** the plan may not cover your expenses. See the *exception –Emergency services and urgent care* sections and the schedule of benefits for specific plan details.

Specific conditions

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

Important note:
Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**.

Birthing center

Eligible health services include prenatal and postpartum care and obstetrical services from your **provider.** After your child is born, **eligible health services** include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Alcohol swabs
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a **provider**.

Mental health treatment

Eligible health services include the treatment of **mental disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation

Substance related disorders treatment

Eligible health services include the treatment of **substance abuse** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate,** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

As used here, "medical complications" include, but are not limited to, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group and family therapies for the treatment of **substance abuse**
  - Other outpatient **substance abuse** treatment such as:
    - Outpatient detoxification
    - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Treatment of withdrawal symptoms
    - Substance use disorder injectables
    - 23 hour observation

Obesity surgery

Eligible health services include obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor will request approval in advance of your obesity surgery. The plan will cover charges made by a **network provider** for the following outpatient weight management services**:**

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the *Outpatient prescription drugs* section

Health care services include one obesity surgical procedure. However, **eligible health services** also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our **network** facilities that perform obesity surgeries.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- **Surgery** needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
  - Other body tissues of the mouth fractured or cut due to **injury.**
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types s:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-Cell receptor therapy for FDA approved treatments

Network of transplant facilities
The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from an **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need.

The National Medical Excellence Program® will coordinate all solid organ, bone marrow and CAR-T and T-Cell therapy services and other specialized care you need.

Important note:
Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

Treatment of infertility

Basic infertility

Eligible health services include seeing a **network provider:**

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (*MRA*)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in the office
- A home care **provider** in your home

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a **health professional**:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

- Purchased by your **provider,** and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home
- And, listed on our **specialty prescription drug** list as covered under this booklet.

You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

Certain injected and infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.
Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure.**
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**, or
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure**, or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.
  (Speech function is the ability to express thoughts, speak words and form sentences).

Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

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

Ambulance service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency services** you need, and
  - The two conditions above are met.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial 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 federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *exclusions* section.

Non-routine/non-preventive care hearing exams

Eligible health services for adults and children include charges for an audiometric hearing exam for evaluation and treatment of **illness**, **injury** or hearing loss, if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist
- An audiologist who is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Nutritional supplements

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Outpatient prescription drugs

What you need to know about your outpatient prescription drug plan

Read this section carefully so that you know:

- How to access **network pharmacies**
- **Eligible health services** under your plan
- What outpatient **prescription drugs** are covered
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **precertification** requirements apply
- How do I request a medical exception
- What your plan doesn't cover – some **eligible health service** exclusions
- How you share the cost of your outpatient **prescription drugs**

Some **prescription drug**s may not be covered or coverage may be limited. This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the *Where your schedule of benefits fits in* section, and see the schedule of benefits.

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

How to access network pharmacies

How do you find a network pharmacy?

You can find a **network pharmacy** in two ways:

- **Online:** By logging onto your Aetna Navigator® secure member website at www.aetna.com.
- **By phone:** Call the toll-free Member Services number on your member ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any of the **network pharmacies**. **Pharmacies** include **network retail**, **mail order** and **specialty pharmacies**.

What if the pharmacy you have been using leaves the network?

Sometimes a **pharmacy** might leave the network. If this happens, you will have to get your **prescriptions** filled at another **network pharmacy**. You can use your **provider directory** or call the toll-free Member Services number on your member ID card to find another **network pharmacy** in your area.

Eligible health services under your plan

What does your outpatient prescription drug plan cover?

Any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section
- They are not carved out in the *What your plan doesn't cover - some eligible health service exceptions* section
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you follow the plan's general rules:

- You need a **prescription** from your **prescriber.**
- Your drug needs to be **medically necessary** for your **illness** or **injury.** See the *Medical necessity and precertification* requirements section.
- You need to show your ID card to the **pharmacy** when you get a **prescription** filled.

Your outpatient **prescription drug** plan includes drugs listed in the **drug guide. Prescription drugs** listed on the **formulary exclusions list** are excluded unless a medical exception is approved by us prior to the drug being picked up at the **pharmacy**. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, you or your **prescriber** must request a medical exception. See the *How to get a medical exception* section.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

What outpatient prescription drugs are covered

Your **prescriber** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **network pharmacy**
- Calling or e-mailing a **network pharmacy** to order the medication
- Submitting your **prescription** electronically

Once you receive a **prescription** from your **prescriber**, you may fill the **prescription** at a **network, retail**, **mail order** or **specialty pharmacy.**

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 90 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Mail order pharmacy

Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

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

Specialty pharmacy

Specialty prescription drugs are covered when dispensed through a **network retail** or **specialty pharmacy.**

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. You can access the list of **specialty care prescription drugs** by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

See the schedule of benefits for details on supply limits and cost sharing.

Other services

Preventive Contraceptives

For females who are able to reproduce, your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method at no cost share.

Important note: You may qualify for a medical exception if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - for blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See your medical plan benefits for coverage of blood glucose meters and insulin pumps.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. You should call the number on your ID card to find a participating **network pharmacy**. You should contact the **pharmacy** for availability, as not all **pharmacies** will stock all available vaccines.

Off-label use

U.S. Food and Drug Administration (FDA)-approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.)
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above.
  - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Preventive care drugs and supplements

Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the ACA guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** used to treat people who are at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Tobacco cessation

(See the *Preventive care and wellness* section of this *booklet-certificate* for information on preventive care tobacco cessation **covered benefits**.)

Eligible health services include charges made by a **network pharmacy** for **prescription drugs** and aids, that are approved by the U. S. Food and Drug Administration, to stop the use of tobacco products. The **prescription drug** or aid must be prescribed by a **prescriber.**

Tobacco product means a substance containing tobacco or nicotine including, but not limited to:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff

- Smokeless tobacco
- Candy-like products that contain tobacco

Over-the-counter (OTC) tobacco cessation aids
Eligible health services include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Limitations:
Eligible health services are limited to two, 90 day courses of treatment each Calendar Year for nicotine replacement therapy. Nicotine replacement therapy means a **prescription drug** or aid that is:

- Used to deliver nicotine to a person attempting to stop the use of tobacco products; and
- Prescribed by a **prescriber**.

Obesity drugs

Eligible health services include charges made by a **network pharmacy** for **prescription drugs** prescribed by a **prescriber** for the sole purpose of weight loss (anti-obesity agents).

You must be diagnosed by a **physician** as having one of the medical conditions listed below. The diagnosis must be documented by a **physician** through the results of a physical exam and outpatient diagnostic lab work.

The medical conditions are:

- **morbid obesity**; and/or
- obesity with **body mass index** levels (for one or more of the following obesity-related risk factors) that are considered serious enough, by the most current generally accepted standards of medical practice, to justify a **prescription drug** treatment plan:
  - Hypertension
  - Dyslipidemia (LDL cholesterol, HDL cholesterol, Triglycerides)
  - Coronary heart disease
  - Type 2 diabetes mellitus
  - Obstructive sleep apnea

Limitations:

- You may not be covered for more than one anti-obesity prescription drug or agent at one time.

How you get an emergency prescription filled

You may not have access to a **network pharmacy** in an emergency or urgent care situation, or you may be traveling outside of the plan's **service area.** If you must fill a **prescription** in either situation, we will reimburse you as shown in the table below.

Type of pharmacy	Your cost share
Network pharmacy	• You pay the **copayment**.
Out-of-network pharmacy	• You pay the **pharmacy** directly for the cost of the **prescription**. Then you fill out and send a **prescription drug** refund form to us, including all itemized **pharmacy** receipts. • Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your **prescription** less your **copayment/payment percentage.**

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your **prescription drug** costs are based on:

- The type of **prescription drug** you're prescribed**.**
- Where you fill your **prescription**.

The plan may, in certain circumstances, make some **brand-name prescription drugs** available to you at the **generic prescription drug copayment** level.

How your outpatient prescription drug deductible works

Your outpatient **prescription drug deductible** is the amount you need to pay for outpatient **prescription drug eligible health services** before your plan begins to pay some or all of the expenses for outpatient **prescription drug eligible health services**.

Your schedule of benefits shows the outpatient **prescription drug deductible** amounts that apply to your plan. Once you have met your outpatient **prescription drug deductible**, we will start sharing the cost when you get outpatient **prescription drug eligible health services**. You will continue to pay **copayments** for **covered benefits** after you satisfy any applicable **deductible**.

How your copayment/payment percentage works

Your **copayment/payment percentage** is the amount you pay for each **prescription** fill or refill in addition to your outpatient **prescription drug deductible**. Your schedule of benefits shows you which **copayments/payment percentage** you need to pay for specific **prescription** fill or refill. You will pay any cost sharing directly to the **network pharmacy**.

How your outpatient prescription drug maximum out-of-pocket limit works

You will pay your outpatient **prescription drug deductible** and **copayments/payment percentage** up to the outpatient **prescription drug maximum out-of-pocket limit** for your plan.

Your schedule of benefits shows the outpatient **prescription drug maximum out-of-pocket limits** that apply to your plan. Once you reach your outpatient **prescription drug maximum out-of-pocket limit**, your plan will pay for outpatient **prescription drug covered benefits** for the remainder of that Calendar Year.

What precertification requirements apply

For certain drugs, you, your **prescriber** or your pharmacist needs to get approval from us before we will cover the drug. This is called "**precertification**". The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are **medically necessary**. For the most up-to-date information, call the toll-free number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You will find the **step therapy prescription drugs** on the **preferred drug guide.** For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

How do I request a medical exception?

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for which health care services are denied through **precertification** or **step therapy**. You, someone who represents you or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the **preferred** or **non-preferred drug** benefit level.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision.

Prescribing units

Some outpatient **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your outpatient **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any outpatient **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Exclusions: What your plan doesn't cover

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exclusions. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

In this section we tell you about the exclusions. We've grouped them to make it easier for you to find what you want.

- Under "General exclusions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exclusions, in "Exclusions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Counseling

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

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy

- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.
Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

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.

Educational services
Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs
- Services provided by a school district.

Examinations
Any health examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies **(experimental or investigational)** or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, or fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Hearing aids and exams

Jaw joint disorder

- Non-surgical treatment of **jaw joint disorder** (TMJ)
- **Jaw joint disorder** treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy service*s section.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages

- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-**prescription drugs** and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the employer or through a third party vendor contract with the employer.

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient **prescription drugs** or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine

- 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 for behavioral health services
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- 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, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF).This also includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care

- Vision care services and supplies, including:
  - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
  - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Additional exclusions for specific types of care

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by or under **physician's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement.

Physicians and other health professionals

There are no additional exclusions specific to **physicians** and other **health professionals**.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital (Hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

- 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 and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Outpatient private duty nursing

(See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Emergency services and urgent care

- **Non-emergency care** in a **hospital** emergency room facility
- Non-urgent care in an **urgent care facility**(at a non-hospital freestanding facility)

Specific conditions

Family planning services - other

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related newborn care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health treatment

- Mental health services for the following categories (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):
  - Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - 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

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
  - **Surgical procedures,** medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Treatment of infertility

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Obtaining sperm from a person not covered under this plan.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

Specific therapies and tests

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.

Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section.

Prosthetic devices

- Services covered under any other benefit
- 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
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes.

Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)

- Including compounded bioidentical hormones

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including **biosimilars** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire,

including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications.
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies.

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care
- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan –Outpatient prescription drugs* section.

Infertility
- **Prescription drugs** used primarily for the treatment of **infertility**.

Injectables:
- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:
- Dispensed by other than a **network retail**, **mail order** and **specialty pharmacies** except as specifically provided in the *What prescription drugs are covered* section.
- Dispensed by a **mail order pharmacy** that is an **out-of-network pharmacy**, except in a medical emergency or urgent care situation except as specifically provided in the *How to get an emergency prescription filled* section.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

- That includes an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.
- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest **prescription** order was written.

Replacement of lost or stolen prescriptions

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network providers**.

Network providers

We have contracted with **providers** in the **service area** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are three exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.
- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section.
- **Network provider not reasonably available** – You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request access to the **out-of-network provider** in advance and we must agree. Contact Member Services at the toll-free number on your ID card for assistance.

You may select a **network provider** from the **directory** through your Aetna Navigator® secure member website at www.aetna.com. You can search our online **directory**, DocFind®, for names and locations of **providers**.

You will not have to submit claims for treatment received from **network providers**. Your **network provider** will take care of that for you. And we will directly pay the **network provider** for what the plan owes.

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

How do you choose your PCP?

You can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, Network providers* section.

Each covered family member is encouraged to select their own **PCP.** You may each select your own **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What will your PCP do for you?

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Your **PCP** can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility.

How do I change my PCP?
You may change your **PCP** at any time. You can call us at the toll-free number on your ID card or log on to your Aetna Navigator® secure member website at www.aetna.com to make a change.

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network.
- You are already a member of **Aetna** and your **provider** stops being in our network.

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is an out-of-network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your **provider** should call **Aetna** for approval to continue any care.
Length of transitional period	Care will continue during a transitional, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the **provider** terminated their participation with **Aetna**.

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **copayments/payment percentage**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

  And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/payment percentage**.

  And then

- The plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary.** See the *Medical necessity requirements* section.
- Usually, when you get an **eligible health service** from someone who is not an **Aetna provider**. See the *Who provides the care* section.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **deductible** or towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your deductible works

Your **deductible** is the amount you need to pay, after paying your **copayment** or **payment percentage**, for **eligible health services** per Calendar Year as listed in the schedule of benefits. Your **copayment** or **payment percentage** does not count toward your **deductible**.

How your copayment/ payment percentage works

Your **copayment/payment percentage** is the amount you pay for **eligible health services** after you have paid your **deductible**. Your schedule of benefits shows you which **copayments/payment percentage** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/payment percentage** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/payment percentage** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered benefits** for the remainder of that **Calendar Year**.

Important note:
See the schedule of benefits for any **deductibles, copayments/ payment percentage, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

Claim decisions and appeals procedures

In the previous section, we explained how you and the plan share responsibility for paying for your **eligible health services**.

When a claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received.

Claim procedures

For claims involving **out-of-network providers:**

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from your employer. • The claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (claim)	• A completed claim form and any additional information required by your employer.	• No later than 90 days after you have incurred expenses for **covered benefits.** • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us. And we will review that claim for payment to the **provider**.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim

A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments/**payment percentage and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable

Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** We will let you know if we need more information to make a decision.

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

In most situations you must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an external review organization (ERO).

You have a right to external review only if:

- Our claim decision involved medical judgment.
- We decided the service or supply is not **medically necessary** or not appropriate.
- We decided the service or supply is **experimental or investigational**.
- You have received an adverse determination.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 123 calendar days (four 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.
- 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

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this *COB* section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section when we talk about a "plan" through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone:** Call the toll-free Member Services number on your ID card.	

COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.
Benefit reserve each family member has a separate benefit reserve for each **calendar year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan

A disability other than ESRD and the employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary **plan** and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free Member Services number on your ID card.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid, or
- Any other plan that is responsible under these COB rules.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued.
- You voluntarily stop your coverage.
- The group contract ends.
- You are no longer eligible for coverage, including when you move out of the service area.
- Your employment ends.
- You do not make any required contributions.
- We end your coverage.
- You become covered under another medical plan offered by your employer.

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by your employer and us.	If required contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: • Your coverage may continue, until stopped by your employer.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer.	If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: • Your coverage will stop on the date that your employment ends.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If contributions are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the employer.
Your employment ends because of a leave of absence that is not a medical leave of absence	If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: • Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence.	If contributions are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

It is your employer's responsibility to let us know when your employment ends. The limits above may be extended only if your employer agrees in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare plans that we offer. However, dependent's coverage will end if your coverage ends under the Medicare plan
- Your dependent has exhausted the maximum benefit under your medical plan.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We will give you 31 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *Administrative information - Intentional deception* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayments for periods after the date your coverage ended.

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the date you stop active work, or the day before the first contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group contract terminates or at the end of the period defined by your employer following the date on which you no longer meet the eligibility requirements.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, which is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/Group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – employer or **Aetna**	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA **– employer or Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice **–** employer or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the employer if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the employer if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the employer if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. The employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the employer within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

To request an extension of coverage**,** just call the toll-free Member Services number on your ID card.

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you or your dependents are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

How can you extend coverage for your disabled child beyond the plan age limits?
You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How can you extend coverage for a child in college on medical leave?
You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury,**
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating doctor as **medically necessary** due to a serious **illness** or **injury.**

The doctor treating your child will be asked to keep us informed of any changes.

General provisions – other things you should know

Administrative information

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group health plan. This document may have amendments too. Under certain circumstances, we or the customer or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or the employer any unearned premium.

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *When you disagree -claim decisions and appeal procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians**, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or the customer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in contributions or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

Financial information

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this plan**.** This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this plan.

Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to

treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO Plan) on coverage

If you are eligible and have chosen medical coverage under an HMO plan offered by the employer, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

If you and your covered dependents:	Change of coverage:	Coverage takes effect:
Live in an HMO plan enrollment area	During an open enrollment period	Group contract anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

Extension of benefits for pregnancy

If you are:	Evidence you must provide:	Extension:	Extension will end the earlier of:
In a hospital not affiliated with the HMO plan	The HMO plan provides an extension of benefits for pregnancy	Same length of time and for the same conditions as the HMO plan provides	• The end of a 90 day period, or • The date the person is not confined

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

Continuation of coverage for other reasons

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a medically necessary leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave?* section.

Sutter Health and Affiliates Services

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices.

Body mass index
This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Copay/Copayments
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary.**
2. You received **precertification** if required.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it prescribed by a **physician** or given by trained medical personnel.

Deductible
The amount you pay for **eligible health services** per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means determined by a **physician** or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of **network providers** for your plan. The most up-to-date directory for your plan appears at www.aetna.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain plans.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage

The date your and your dependent's coverage begins under this booklet as noted in your employer's records.

Eligible health services

The health care services and supplies and **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *exclusions* section or in the schedule of benefits**.**

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services.**

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency services

Treatment given in a **hospital**'s emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition.**

Experimental or investigational

A drug, device, procedure, or treatment that is found to be **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Formulary exclusions list

A list of **prescription drugs** not covered under the plan**.** This list is subject to change.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
Poor health resulting from disease of the body or mind.

Infertile/infertility
A disease defined by the failure to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Injury
Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility
A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)
Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A myofascial pain dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

A pharmacy where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and payment percentage including any **deductible**, to be paid by you or any covered dependents per Calendar Year for **eligible health services**.

Medically necessary/Medical necessity

Health care services that a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

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**.

*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 an additional service or risk charge set by us.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

The rebates will not change the **negotiated charge** under this plan.

We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network pharmacy

A **retail pharmacy**, **mail order pharmacy** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Network provider

A **provider** listed in the **directory** for your plan. However, a NAP provider listed in the NAP directory is not a **network provider**.

Non-preferred drug

A **prescription drug** or device that may have a higher out-of-pocket cost than a **preferred drug**.

Out-of-network provider

A **provider** who is not a **network provider.**

Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Payment Percentage
The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Pharmacy
An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Preferred drug
A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Preferred drug guide
A list of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Aetna** or an affiliate. A copy of the **preferred drug guide** is available at your request. Or you can find it on the **Aetna** website at www.aetna.com/formulary.

Preferred network pharmacy
A **network retail pharmacy** that **Aetna** has identified as a **preferred network pharmacy**.

Prescriber
Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug
An FDA approved drug or biological which can only be dispensed by **prescription.**

Primary care physician (PCP)
A **physician** who:

- The **directory** lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist, a pediatrician
- Is shown on **Aetna**'s records as your **PCP**

Provider(s)
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital

An institution specifically licensed or certified as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders** (including substance-related disorders) or mental **illnesses**.

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a **psychiatrist** at least once per week.
- The medical director must be a **psychiatrist**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

Residential treatment facility (substance abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for chemical dependence residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for chemical dependence **detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting.
- Residential care must be provided under the direct supervision of a **physician**.

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospital**s, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance abuse**.

Skilled nursing services

Services provided by an **R.N.** or **L.P.N.** within the scope of their license.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs

These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling the toll-free number on your ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com.

Specialty pharmacy

This is a **pharmacy** designated by Aetna as a **network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Substance abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include conditions you cannot attribute to a **mental disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

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 , except for behavioral health services
- Any other method required by state law

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Therapeutic drug class
A group of drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or **injury**.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Discount programs

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service providers". These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and Other Incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services and continue participation as an **Aetna** member through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to **copayment**, **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards, or
- Any combination of the above.

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

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

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

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

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

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

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

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

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

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the

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

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

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

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

EXHIBIT B

FORM 1.997. CIVIL COVER SHEET

The civil cover sheet and the information contained in it neither replace nor supplement the filing and service of pleadings or other documents as required by law. This form must be filed by the plaintiff or petitioner with the Clerk of Court for the purpose of reporting uniform data pursuant to section 25.075, Florida Statutes. (See instructions for completion.)

I. CASE STYLE

IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT,
IN AND FOR PINELLAS COUNTY, FLORIDA

Scott Lake
Plaintiff

Case # _____
Judge _____

vs.
Aetna Life Insurance Company, The School Board of Pinellas County
Defendant

II. AMOUNT OF CLAIM

Please indicate the estimated amount of the claim, rounded to the nearest dollar. The estimated amount of the claim is requested for data collection and clerical processing purposes only. The amount of the claim shall not be used for any other purpose.

☐ $8,000 or less
☐ $8,001 - $30,000
☐ $30,001- $50,000
☐ $50,001- $75,000
☐ $75,001 - $100,000
☒ over $100,000.00

III. TYPE OF CASE (If the case fits more than one type of case, select the most definitive category.) If the most descriptive label is a subcategory (is indented under a broader category), place an x on both the main category and subcategory lines.

CIRCUIT CIVIL

☐ Condominium
☒ Contracts and indebtedness
☐ Eminent domain
☐ Auto negligence
☐ Negligence—other
- ☐ Business governance
- ☐ Business torts
- ☐ Environmental/Toxic tort
- ☐ Third party indemnification
- ☐ Construction defect
- ☐ Mass tort
- ☐ Negligent security
- ☐ Nursing home negligence
- ☐ Premises liability—commercial
- ☐ Premises liability—residential

☐ Products liability
☐ Real Property/Mortgage foreclosure
- ☐ Commercial foreclosure
- ☐ Homestead residential foreclosure
- ☐ Non-homestead residential foreclosure
- ☐ Other real property actions

☐Professional malpractice
- ☐ Malpractice—business
- ☐ Malpractice—medical
- ☐ Malpractice—other professional

☐ Other
- ☐ Antitrust/Trade regulation
- ☐ Business transactions
- ☐ Constitutional challenge—statute or ordinance
- ☐ Constitutional challenge—proposed amendment
- ☐ Corporate trusts
- ☐ Discrimination—employment or other
- ☐ Insurance claims
- ☐ Intellectual property
- ☐ Libel/Slander
- ☐ Shareholder derivative action
- ☐ Securities litigation
- ☐ Trade secrets
- ☐ Trust litigation

COUNTY CIVIL

☐ Small Claims up to $8,000
☐ Civil
☐ Real property/Mortgage foreclosure

☐ Replevins
☐ Evictions
    ☐ Residential Evictions
    ☐ Non-residential Evictions
☐ Other civil (non-monetary)

COMPLEX BUSINESS COURT

This action is appropriate for assignment to Complex Business Court as delineated and mandated by the Administrative Order. Yes ☒ No ☐

IV. REMEDIES SOUGHT (check all that apply):
☒ Monetary;
☐ Nonmonetary declaratory or injunctive relief;
☐ Punitive

V. NUMBER OF CAUSES OF ACTION: [ ]
(Specify)

4

VI. IS THIS CASE A CLASS ACTION LAWSUIT?
☒ yes
☐ no

VII. HAS NOTICE OF ANY KNOWN RELATED CASE BEEN FILED?
☒ no
☐ yes If "yes," list all related cases by name, case number, and court.

VIII. IS JURY TRIAL DEMANDED IN COMPLAINT?
☒ yes
☐ no

I CERTIFY that the information I have provided in this cover sheet is accurate to the best of my knowledge and belief, and that I have read and will comply with the requirements of Florida Rule of Judicial Administration 2.425.

Signature: s/ Maria D Garcia — Fla. Bar # 58635
Attorney or party — (Bar # if attorney)

Maria D Garcia — 10/30/2020
(type or print name) — Date

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,
v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

TO: THE SCHOOL BOARD OF PINELLAS COUNTY
Dr. Michael Grego, Superintendent
301 4th Street SW
Largo, FL 33770

YOU ARE HEREBY SUMMONED and required to serve upon PLAINTIFF'S ATTORNEY:

Maria D. Garcia, Esq.
KOZYAK TROPIN & THROCKMORTON LLP
2525 Ponce de Leon Blvd., 9th Floor
Coral Gables, Florida 33134
Tel: (305) 372-1800
Fax: (305) 372-3508
E-mail: mgarcia@kttlaw.com

KEN BURKE CLERK CIRCUIT COURT
315 Court Street
Clearwater, Pinellas County, FL 33756-5165

an answer or other response to the Complaint which is served upon you, within 20 days after service of this Summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the Complaint.

Thomas Smith
_____ DEPUTY CLERK
CLERK OF COURT

NOV 05 2020
_____
DATE

RETURN OF SERVICE

Service of the Summons and Complaint was made by me

PRINT NAME & TITLE OF SERVER _____ DATE _____

Check one box below to indicate appropriate method of service:

☐ Served personally upon the defendant. Place where served:

_____

_____

☐ Left copies thereof at the defendant's dwelling house or usual place of abode with a person of suitable age and discretion then residing therein. Name and physical description of person:

_____

_____

☐ Returned unexecuted:

_____

_____

☐ Other (specify):

_____

_____

DECLARATION OF SERVER

I declare under penalty of perjury under the laws of the United States of America that the foregoing information contained in the Return of Service and Statement of Service Fees is true and correct.

Executed on _____, 2020
Date

_____
Signature of Server

_____
Address of Server

5362/101/12I3937

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,
v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

TO: AETNA LIFE INSURANCE COMPANY
c/o Chief Financial Officer, Registered Agent
200 East Gaines Street
Tallahassee, FL 32399-4201

YOU ARE HEREBY SUMMONED and required to serve upon PLAINTIFF'S ATTORNEY:

Maria D. Garcia, Esq.
KOZYAK TROPIN & THROCKMORTON LLP
2525 Ponce de Leon Blvd., 9th Floor
Coral Gables, Florida 33134
Tel: (305) 372-1800
Fax: (305) 372-3508
E-mail: mgarcia@kttlaw.com

KEN BURKE CLERK CIRCUIT COURT
315 Court Street
Clearwater, Pinellas County, FL 33756-5165

an answer or other response to the Complaint which is served upon you, within 20 days after service of this Summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the Complaint.

_____ DEPUTY CLERK
CLERK OF COURT

NOV 05 2020
DATE

Summons

RETURN OF SERVICE

Service of the Summons and Complaint was made by me

PRINT NAME & TITLE OF SERVER _____ DATE _____

Check one box below to indicate appropriate method of service:

☐ Served personally upon the defendant. Place where served:

_____

_____

☐ Left copies thereof at the defendant's dwelling house or usual place of abode with a person of suitable age and discretion then residing therein. Name and physical description of person:

_____

_____

☐ Returned unexecuted:

_____

_____

☐ Other (specify):

_____

_____

DECLARATION OF SERVER

I declare under penalty of perjury under the laws of the United States of America that the foregoing information contained in the Return of Service and Statement of Service Fees is true and correct.

Executed on _____, 2020
Date

_____
Signature of Server

_____
Address of Server

5362/101/1213579

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

NOTICE OF APPEARANCE AND DESIGNATION OF EMAIL ADDRESSES

NOTICE is hereby given that Frank A. Florio, of the law firm of Kozyak Tropin & Throckmorton LLP, hereby appears as co-counsel for Plaintiff Scott Lake, and all others similarly situated, and requests that any and all pleadings or other matters pertaining to this cause be directed to him on behalf of Plaintiff. Further, counsel designates the following email addresses for purposes of service:

Frank A. Florio Primary email: fflorio@kttlaw.com
Secondary email: ya@kttlaw.com

Respectfully submitted,

KOZYAK TROPIN & THROCKMORTON, LLP
Counsel for Plaintiffs and Classes
2525 Ponce de Leon, 9th Floor
Coral Gables, Florida 33134
Telephone: (305) 372-1800
Facsimile: (305) 372-3508

By: *s/ Frank A. Florio*

Harley S. Tropin
Florida Bar No. 241253
Email: hst@kttlaw.com
Maria D. Garcia
Florida Bar No. 58635
Email: mgarcia@kttlaw.com
Robert J. Neary
Florida Bar No. 81712
Email: rn@kttlaw.com
Frank A. Florio
Florida Bar No. 1010461
Email: fflorio@kttlaw.com

and

Stephanie A. Casey, Esq.
Florida Bar No. 97483
scasey@colson.com
COLSON HICKS EIDSON
255 Alhambra Circle, Penthouse
Coral Gables, Florida 33134
Telephone: (305) 476-7400
Facsimile: (305) 476-7444
E-mail: eservice@colson.com

Counsel for Plaintiff and the Putative Class

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on November 3, 2020, I electronically filed the foregoing document with the Clerk of the Court through the Florida ePortal and that the foregoing document was served by an automatic email generated by the Florida Courts e-Filing Portal.

By: */s/ Frank A. Florio*
Frank A. Florio

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

NOTICE OF APPEARANCE AND DESIGNATION OF EMAIL ADDRESSES

NOTICE is hereby given that Robert J. Neary, of the law firm of Kozyak Tropin & Throckmorton LLP, hereby appears as co-counsel for Plaintiff Scott Lake, and all others similarly situated, and requests that any and all pleadings or other matters pertaining to this cause be directed to him on behalf of Plaintiff. Further, counsel designates the following email addresses for the purpose of service:

Robert J. Neary Primary email: rn@kttlaw.com
Secondary email: pm@kttlaw.com

Respectfully submitted,

KOZYAK TROPIN & THROCKMORTON, LLP
Counsel for Plaintiffs and Classes
2525 Ponce de Leon, 9th Floor
Coral Gables, Florida 33134
Telephone: (305) 372-1800
Facsimile: (305) 372-3508

By: */s/ Robert J. Neary*

Harley S. Tropin
Florida Bar No. 241253
Email: hst@kttlaw.com
Maria D. Garcia
Florida Bar No. 58635
Email: mgarcia@kttlaw.com
Robert J. Neary
Florida Bar No. 81712
Email: rn@kttlaw.com
Frank A. Florio
Florida Bar No. 1010461
Email: fflorio@kttlaw.com

and

Stephanie A. Casey, Esq.
Florida Bar No. 97483
scasey@colson.com
COLSON HICKS EIDSON
255 Alhambra Circle, Penthouse
Coral Gables, Florida 33134
Telephone: (305) 476-7400
Facsimile: (305) 476-7444
E-mail: eservice@colson.com

Counsel for Plaintiff and the Putative Class

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on November 3, 2020, I electronically filed the foregoing document with the Clerk of the Court through the Florida ePortal and that the foregoing document was served by an automatic email generated by the Florida Courts e-Filing Portal.

By: */s/ Robert J. Neary*
Robert J. Neary

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

Case No. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

NOTICE OF APPEARANCE OF COUNSEL

PLEASE TAKE NOTICE that Stephanie A. Casey, of the law firm Colson Hicks Eidson, P.A., hereby enters her appearance as co-counsel for Plaintiff SCOTT LAKE and the Putative Class, and respectfully requests that all pleadings, notices, orders and correspondence, and other papers in connection with these actions be served on the undersigned at:

E-mail address: scasey@colson.com;
Alternate e-mail addresses: becky@colson.com; michelle@colson.com

Dated: November 4, 2020

Respectfully submitted,

COLSON HICKS EIDSON, P.A.
255 Alhambra Circle, Penthouse
Coral Gables, Florida 33134
Tel: 305-476-7400;Fax: 305-476-7444
By: /s/ Stephanie A. Casey
Stephanie A. Casey
Florida Bar No. 97483
E-mail: scasey@colson.com

CERTIFICATE OF ELECTRONIC FILING AND SERVICE

I HEREBY CERTIFY, that on November 4, 2020, I caused the foregoing document to be electronically filed with the Clerk of the Court. I also certify that the foregoing document is being served this day on all counsel of record via transmission of Notices of Electronic Filing generated by the Clerk of Court.

/s/ Stephanie A. Casey
Stephanie A. Casey

Colson Hicks Eidson
255 Alhambra Circle, Penthouse, Coral Gables, Florida 33134-5008 Telephone: (305) 476-7400 Fax: (305) 476-7444

RETURN OF SERVICE

State of Florida **County of Pinellas** **Circuit Court**

Case Number: 20-005171-CI

Plaintiff:
SCOTT LAKE

vs.

Defendant:
AETNA LIFE INSURANCE COMPANY; and THE SCHOOL BOARD OF PINELLAS COUNTY

For:
Maria Garcia
KOZYAK TROPIN & THROCKMORTON, LLP

Received by DLE Process Servers, Inc on the 11th day of November, 2020 at 4:27 pm to be served on **Aetna Life Insurance Company c/o Chief Financial Officer as Registered Agent, 200 East Gaines Street, Tallahassee, FL 32399**.

I, Richard Kolodgy, do hereby affirm that on the **12th day of November, 2020** at **1:00 pm, I:**

served a **CORPORATION** by delivering a true copy of the **Summons, Request for Production, First Set of Interrogatories, Complaint, Exhibits and Chief Financial Processing Fee $15.00** at **200 East Gaines Street, Tallahassee, FL 32399** with the date and hour of service endorsed thereon by me, to: **Colby Nutting** as **Senior Word Processor** for **Chief Financial Officer, REGISTERED AGENT** on behalf of **Aetna Life Insurance Company** and informing said person of the contents therein, in compliance state statutes.

I certify that I am over the age of 18, have no interest in the above action, and am a Certified Process Server, in good standing, in the judicial circuit in which the process was served.

Under penalties of perjury, I declare that I have read the foregoing Verified Return of Service and that the facts stated are true. F.S. 92.525. NOTARY NOT REQUIRED PURSUANT TO F.S. 92.525

Richard Kolodgy
Process Server #204

DLE Process Servers, Inc
936 Sw 1st Avenue
#261
Miami, FL 33130
(786) 220-9705

Our Job Serial Number: DLE-2020046484

Filing # 116065874 E-Filed 11/03/2020 01:42:15 PM

Nov 12, 2020
1:09pm
Colby Nutting
R.K. # 204

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

TO: AETNA LIFE INSURANCE COMPANY
c/o Chief Financial Officer, Registered Agent
200 East Gaines Street
Tallahassee, FL 32399-4201

YOU ARE HEREBY SUMMONED and required to serve upon PLAINTIFF'S ATTORNEY:

Maria D. Garcia, Esq.
KOZYAK TROPIN & THROCKMORTON LLP
2525 Ponce de Leon Blvd., 9th Floor
Coral Gables, Florida 33134
Tel: (305) 372-1800
Fax: (305) 372-3508
E-mail: mgarcia@kttlaw.com

KEN BURKE CLERK CIRCUIT COURT
315 Court Street
Clearwater, Pinellas County, FL 33756-5165

an answer or other response to the Complaint which is served upon you, within 20 days after service of this Summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the Complaint.

_____ DEPUTY CLERK
CLERK OF COURT

NOV 05 2020
DATE

Summons

RETURN OF SERVICE

State of Florida **County of Pinellas** **Circuit Court**

Case Number: 20-005171-CI

Plaintiff:
SCOTT LAKE

vs.

Defendant:
AETNA LIFE INSURANCE COMPANY; and THE SCHOOL BOARD OF PINELLAS COUNTY

For:
Maria Garcia
KOZYAK TROPIN & THROCKMORTON, LLP

Received by DLE Process Servers, Inc on the 11th day of November, 2020 at 4:27 pm to be served on **The School Board of Pinellas County c/o Dr. Michael Grego, Superintendent, 301 4th Street SW, Largo, FL 33770**.

I, Michele Carpintier, do hereby affirm that on the **17th day of November, 2020** at **1:46 pm, I:**

served a **PUBLIC AGENCY** by delivering a true copy of the **Summons, Request for Production, First Set of Interrogatories, Complaint and Exhibits.** with the date and hour of service endorsed thereon by me, to: **Kim Christy** as **Secretary** for **The School Board of Pinellas County c/o Dr. Michael Grego, Superintendent** at the address of: **301 4th Street SW, Largo, FL 33770** and informing said person of the contents therein.

I certify that I am over the age of 18, have no interest in the above action, and am a Certified Process Server, in good standing, in the judicial circuit in which the process was served.

Under penalties of perjury, I declare that I have read the foregoing Verified Return of Service and that the facts stated are true. F.S. 92.525. NOTARY NOT REQUIRED PURSUANT TO F.S. 92.525

Michele Carpintier
APS 26478

DLE Process Servers, Inc
936 Sw 1st Avenue
#261
Miami, FL 33130
(786) 220-9705

Our Job Serial Number: DLE-2020046486

Filing # 116065874 E-Filed 11/03/2020 01:42:15 PM

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

11/17/20
1:46pm
Kim Christy
APS 26478

TO: THE SCHOOL BOARD OF PINELLAS COUNTY
Dr. Michael Grego, Superintendent
301 4th Street SW
Largo, FL 33770

YOU ARE HEREBY SUMMONED and required to serve upon PLAINTIFF'S ATTORNEY:

Maria D. Garcia, Esq.
KOZYAK TROPIN & THROCKMORTON LLP
2525 Ponce de Leon Blvd., 9th Floor
Coral Gables, Florida 33134
Tel: (305) 372-1800
Fax: (305) 372-3508
E-mail: mgarcia@kttlaw.com

KEN BURKE CLERK CIRCUIT COURT
315 Court Street
Clearwater, Pinellas County, FL 33756-5165

an answer or other response to the Complaint which is served upon you, within 20 days after service of this Summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the Complaint.

Thomas Smith DEPUTY CLERK
CLERK OF COURT

NOV 05 2020
DATE

Summons

IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND
FOR PINELLAS COUNTY, FLORIDA

CIVIL DIVISION

CASE NO. 20-005171-CI

SCOTT LAKE,
on behalf of himself and
all others similarly situated,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; and
THE SCHOOL BOARD OF PINELLAS
COUNTY,

Defendants.
_____/

PLAINTIFF'S NOTICE OF SERVING FIRST SET OF INTERROGATORIES AND FIRST REQUEST FOR PRODUCTION ON DEFENDANTS AETNA LIFE INSURANCE COMPANY AND THE SCHOOL BOARD OF PINELLAS COUNTY

Plaintiff, Scott Lake ("Mr. Lake"), by and through undersigned counsel, hereby gives notice of serving its First Set of Interrogatories and First Request for Production on Defendants, Aetna Life Insurance Company, c/o Chief Financial Officer as Registered Agent, 200 East Gaines Street, Tallahassee, FL 32399 on November 12, 2020, and The School Board of Pinellas County, by serving Dr. Michael Grego, Superintendent, 301 4th Street SW, Largo, Florida 33770 on November 17, 2020.

Respectfully submitted,

KOZYAK TROPIN & THROCKMORTON LLP
Counsel for Plaintiffs and Classes
2525 Ponce de Leon, 9th Floor
Coral Gables, Florida 33134
Telephone: (305) 372-1800
Facsimile: (305) 372-3508

By: */s/ Maria D. Garcia*
Harley S. Tropin
Florida Bar No. 241253
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and

COLSON HICKS EIDSON, P.A.
255 Alhambra Circle, Penthouse
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By: *s/ Stephanie A. Casey*
Dean C. Colson, Esq.
Florida Bar No. 228702
Email: dean@colson.com
Stephanie A. Casey, Esq.
Florida Bar No. 97483
Email: scasey@colson.com

Counsel for Plaintiff and the Putative Class

CERTIFICATE OF SERVICE

I HEREBY CERTIFY on this 19th day of November, 2020, that Plaintiff's First Set of Interrogatories and First Request for Production were served on Defendant Aetna Life Insurance Company, c/o Chief Financial Officer as Registered Agent, 200 East Gaines Street, Tallahassee, FL 32399 on November 12, 2020, and The School Board of Pinellas County , c/o Dr. Michael Grego, Superintendent, 301 4th Street SW, Largo, Florida 33770 on November 17, 2020.

By: /s/*Maria D. Garcia*
Maria D. Garcia

**IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT,
IN AND FOR PINELLAS COUNTY, FLORIDA**

SCOTT LAKE,

Plaintiff,

Case No.: 20-005171-CI
Civil Division

vs.

AETNA LIFE INSURANCE COMPANY, and THE SCHOOL BOARD OF PINELLAS COUNTY,

Defendants.
_____/

**JOINT STIPULATION FOR EXTENSION OF TIME
TO RESPOND TO PLAINTIFF'S COMPLAINT**

Defendant, AETNA LIFE INSURANCE COMPANY ("Aetna") and Plaintiff, SCOTT LAKE (the "Plaintiff"), by and through their undersigned counsel, hereby stipulate and agree to an extension of time, up to and including Tuesday, December 22, 2020, for Aetna to file its response to the Plaintiff's Class Action Complaint (the "Complaint"). In support thereof, the Parties state as follows:

1. Aetna was served by the Plaintiff through the Florida Department of Financial Service, Florida's Chief Financial Officer, on or about November 18, 2020.

2. As a result, Aetna's response to the Complaint is currently due on December 8, 2020.

3. Due to the intervening Thanksgiving holiday and the complexity of the matter, additional time is required to investigate and respond to the claims asserted against Aetna. The Parties have agreed and stipulated to an extension of time, up to and including Tuesday, December 22, 2020, for Aetna to respond to the Complaint.

4. Accordingly, Aetna shall respond to the Complaint on or before Tuesday, December 22, 2020.

5. Such stipulation does not waive, and is without prejudice to, any claims, counterclaims or defenses either party may otherwise have. Moreover, this stipulation is not made for the purpose of delay and neither party would be prejudiced by a limited extension.

Dated: December 2, 2020

/s/ Stephanie A. Casey
Stephanie A. Casey, Esq.
Florida Bar No. 97483
scasey@colson.com
COLSON HICKS EIDSON
255 Alhambra Circle, Penthouse
Coral Gables, Florida 33134
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– and –

/s/ Maria D. Garcia
Harley S. Tropin, Esq.
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Maria D. Garcia, Esq.
Florida Bar No. 58635
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Counsel for Plaintiff

/s/ Ardith Bronson
Ardith Bronson, Esq.
Florida Bar No.: 423025
ardith.bronson@dlapiper.com
Maia Sevilla-Sharon
Florida Bar No.: 123929
maia.sevillasharon@dlapiper.com
DLA Piper LLP (US)
200 S. Biscayne Blvd. Suite 2500
Miami, FL 33131
Telephone: (305) 423-8562

Counsel for Defendant Aetna Life Insurance Company

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this December 2, 2020, a true and correct copy of the foregoing was furnished electronically upon filing with e-Filing portal to all counsel of record.

By: */s/ Ardith Bronson*
Ardith Bronson, Esq.

**IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT,
IN AND FOR PINELLAS COUNTY, FLORIDA**

SCOTT LAKE,

Plaintiff,

Case No.: 20-005171-CI
Civil Division

vs.

AETNA LIFE INSURANCE COMPANY, and THE SCHOOL BOARD OF PINELLAS COUNTY,

Defendants.
_____/

**NOTICE OF APPEARANCE AND
DESIGNATION OF E-MAIL ADDRESSES FOR SERVICE**

PLEASE TAKE NOTICE that Ardith Bronson, Esq. of DLA Piper LLP (US) hereby files her appearance as counsel for the Defendant, AETNA LIFE INSURANCE COMPANY ("Aetna"), and requests that all notices, demands, motions, orders, dismissals, and pleadings to be served on Aetna be forwarded to its undersigned counsel.

PLEASE TAKE NOTICE that pursuant to Rule 2.516 of the Florida Rules of Judicial Administration, the undersigned counsel for Aetna hereby provides notification of the following email addresses for the purpose of receiving pleadings and papers in the above styled case:

1. Primary: ardith.bronson@dlapiper.com
2. Secondary: eServiceMiami@dlapiper.com

In the event you receive notification that an email sent to the above addresses did not go through, please contact our office at the telephone number below.

Dated: December 3, 2020

DLA PIPER LLP (US)

/s/ Ardith Bronson
Ardith Bronson, Esq. (FBN 423025)
ardith.bronson@dlapiper.com
DLA Piper LLP (US)
200 South Biscayne Blvd., Suite 2500
Miami, FL 33131
Tel.: (305) 423-8562

Counsel for Defendant
Aetna Life Insurance Company

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this December 3, 2020, a true and correct copy of the foregoing was furnished electronically upon filing with e-Filing portal to all counsel of record.

By: */s/ Ardith Bronson*
Ardith Bronson, Esq.

**IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT,
IN AND FOR PINELLAS COUNTY, FLORIDA**

SCOTT LAKE,

Plaintiff,

Case No.: 20-005171-CI
Civil Division

vs.

AETNA LIFE INSURANCE COMPANY, and THE SCHOOL BOARD OF PINELLAS COUNTY,

Defendants.
_____/

**NOTICE OF APPEARANCE AND
DESIGNATION OF E-MAIL ADDRESSES FOR SERVICE**

PLEASE TAKE NOTICE that Maia Sevilla-Sharon, Esq. of DLA Piper LLP (US) hereby files her appearance as counsel for the Defendant, AETNA LIFE INSURANCE COMPANY ("Aetna"), and requests that all notices, demands, motions, orders, dismissals, and pleadings to be served on Aetna be forwarded to its undersigned counsel.

PLEASE TAKE NOTICE that pursuant to Rule 2.516 of the Florida Rules of Judicial Administration, the undersigned counsel for Aetna hereby provides notification of the following email addresses for the purpose of receiving pleadings and papers in the above styled case:

1. Primary: maia.sevillasharon@dlapiper.com
2. Secondary: eServiceMiami@dlapiper.com

In the event you receive notification that an email sent to the above addresses did not go through, please contact our office at the telephone number below.

Dated: December 3, 2020

DLA PIPER LLP (US)

/s/ Maia Sevilla-Sharon
Maia Sevilla-Sharon, Esq. (FBN 123929)
maia.sevillasharon@dlapiper.com
DLA Piper LLP (US)
200 South Biscayne Blvd., Suite 2500
Miami, FL 33131
Tel.: (305) 423-8527

Counsel for Defendant
Aetna Life Insurance Company

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this December 3, 2020, a true and correct copy of the foregoing was furnished electronically upon filing with e-Filing portal to all counsel of record.

By:*/s/ Maia Sevilla-Sharon*
Maia Sevilla-Sharon, Esq.

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

SCOTT LAKE, on behalf of himself and all others similarly situated

(b) County of Residence of First Listed Plaintiff Pinellas County, FL
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Colson Hicks Eidson, 255 Alhambra Circle, Coral Gables, FL 33134; Ph: 305-476-7400

DEFENDANTS

AETNA LIFE INSURANCE COMPANY; THE SCHOOL BOARD OF PINELLAS COUNTY

County of Residence of First Listed Defendant Hartford, CT
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

For Aetna: DLA Piper LLP (US), 200 S. Biscayne Blvd., Ste. 2500, Miami, FL 33131, Ph: 305-423-8562

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☒ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☒ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- ☐ 1 Original Proceeding
- ☒ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from Another District *(specify)*
- ☐ 6 Multidistrict Litigation - Transfer
- ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
28 U.S.C. 1332(d)(2)

Brief description of cause: Putative class action alleging claims for unjust enrichment, breach of the covenant of good faith and fair dealing, and declaratory and injunctive relief relating to the denial of health benefits.

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $ monetary, declaratory, and injunctive relief in excess of $5 million

CHECK YES only if demanded in complaint:

JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
Dec. 17, 2020

SIGNATURE OF ATTORNEY OF RECORD
/s/ Ardith Bronson

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____