MASTER SERVICES AGREEMENT
BETWEEN
AETNA LIFE INSURANCE COMPANY
AND
THE GOVERNMENT OF GUAM
FOR DENTAL SERVICES ONLY

This master services agreement ("Agreement") between AETNA LIFE INSURANCE COMPANY, a Connecticut corporation, ("Aetna"), and THE GOVERNMENT OF GUAM("Customer") is effective as of October 1, 2019 ("Effective Date").

The Customer has established a self-funded employee benefits plan, described in Exhibit 1 (Dental Service Schedule), (the “Plan(s)”), for certain covered persons, as defined in the Plan(s) (the “Plan Participants”).

The Customer wants to make available to Plan Participants one or more products and administrative services ("Services") offered by Aetna, as specified in the attached schedules, and Aetna wants to provide those Services to the Customer for the compensation described herein in Exhibit 2 (Service and Fee Schedule).

The parties therefore agree as follows:

1. TERM

The term of this Agreement will be one year beginning on the Effective Date. The term shall be considered an "Agreement Period".

2. SERVICES

Aetna shall provide the Services described in Exhibit 1 (Dental Service Schedule).

3. STANDARD OF CARE

Aetna and the Customer will discharge their obligations under this Agreement with that level of reasonable care which a similarly situated services provider or plan administrator, respectively, would exercise under similar circumstances. If the Customer delegates claim fiduciary duties to Aetna pursuant to the applicable schedule, Aetna shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404(a)(1)(B).

4. SERVICE FEES

The Customer shall pay Aetna the fees according to the Service and Fee Schedule ("Service Fees").

Aetna shall provide the Customer with a monthly statement indicating the Service Fees owed for that month. The Customer shall pay Aetna the Service Fees no later than 31 calendar days after the first calendar day of the month in which the Services are provided (the "Payment Due Date"). The Customer shall provide with their payment either a copy of the Aetna invoice, modified to reflect current eligibility, or a copy of a pre-approved invoice which meets Aetna’s billing requirements. The Customer shall also reimburse Aetna for certain additional expenses, as stated in the Service and Fee Schedule.

All overdue amounts are subject to the late charges as set forth in Article 5 of Chapter 22 of 5 Guam Code Annotated. Aetna shall prepare and submit to the Customer an annual report showing the Service Fees paid.

5. BENEFIT FUNDING

The Customer shall choose one of the banking facilities offered by Aetna through which Plan benefit payments, Service Fees and Plan benefit related charges will be made. All such amounts will be paid through the banking facility by check, electronic funds transfer or other reasonable transfer methods. The Customer shall reimburse the Master Services Agreement – Dental Services 1 10.18.2019
banking facility for all such payments on the day of the request. All such reimbursements will be made by wire transfer in federal funds using the instructions provided by Aetna, or by another transfer method agreed upon by both parties.

Since funding is provided on a checks issued basis, Customer and Aetna agree that outstanding payments to providers (e.g., uncashed checks or checks not presented for payment) will be handled in the manner indicated and memorialized by the Parties in a separate form letter. The terms and conditions of this Agreement shall apply to that letter.

In the event that Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(B) (Termination), Aetna may place a stop payment order on all of the Customer’s outstanding benefit checks.

6. FIDUCIARY DUTY

It is understood and agreed that the Customer, as plan administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided there under, and that Aetna is empowered to act on behalf of the Customer in connection with the Plan only to the extent expressly stated in this Agreement or as agreed to in writing by Aetna and the Customer.

The Customer has the sole and complete authority to determine eligibility of persons to participate in the Plan.

Claim fiduciary responsibility is identified in the applicable Schedule.

7. CUSTOMER’S RESPONSIBILITIES

(A) Eligibility – The Customer shall supply Aetna, by electronic medium acceptable to Aetna, with all relevant information identifying Plan Participants and shall notify Aetna by the tenth day of the month following any changes in Plan participation. Aetna is not required to honor a notification of termination of a Plan Participant’s eligibility which Aetna receives more than 60 days after termination of such Plan Participant. Aetna has no responsibility for determining whether an individual meets the eligibility requirements of the Plan.

(B) Plan Document Review – The Customer shall provide Aetna with all Plan documents at least 30 days prior to the Effective Date. Aetna will review the Plan documents to determine any potential differences that may exist among such Plan documents and Aetna’s claim processing systems and internal policies and procedures. Aetna does NOT review the Customer’s Summary of Benefits and Coverage (“SBC”), Summary Plan Description (“SPD”) or other Plan documents for compliance with applicable law. The Customer also agrees that it is responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law, including updating the SBC or SPD and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

(C) Notice of Plan or Benefit Change – The Customer shall notify Aetna in writing of any changes in Plan documents or Plan benefits (including changes in eligibility requirements) at least 30 days prior to the effective date of such changes. Aetna will have 30 days following receipt of such notice to inform the Customer whether Aetna will agree to administer the proposed changes. If the proposed changes increase Aetna’s costs, alter Aetna’s ability to meet any performance standards or otherwise impose substantial operational challenges, Aetna may require an adjustment to the Service Fees or other financial terms.

Master Services Agreement – Dental Services 2 10.18.2019
(D) Employee Notices – The Customer shall furnish each Employee covered by the Plan written notice that the Customer has complete financial liability for the payment of Plan benefits. The Customer shall inform its Plan Participants, in a manner that satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with plan administration.

(E) Third Party Consents – The Customer shall obtain any consents, authorizations or other permissions from Employees or relevant third parties, which may be required under law or otherwise necessary in order for Aetna to access, use or disclose information and data for the purposes of providing Services under this Agreement.

(F) Miscellaneous – The Customer shall promptly provide Aetna with such information regarding administration of the Plan as required by Aetna to perform its obligations and as Aetna may otherwise reasonably request from time to time. Such information shall include, at no cost to Aetna, all relevant medical records, lab and pharmacy data, claim and other information pertaining to Plan Participants and/or Employees. Aetna is entitled to rely on the information most recently supplied by the Customer in connection with the Services and Aetna’s other obligations under the Agreement. Aetna is not responsible for any delay or error caused by the Customer’s failure to furnish correct information in a timely manner. Aetna is not responsible for responding to Plan Participant requests for copies of Plan documents. The Customer shall be liable for all Plan benefit payments made by Aetna, including those payments made following the termination date or which are outstanding on the termination date.

8. RECORDS

Aetna, its affiliates and authorized agents shall use all Plan-related documents, records and reports received or created by Aetna in the course of delivering the Services ("Plan Records") in compliance with applicable privacy laws and regulations. Aetna may de-identify Plan Records and use them for quality improvement, statistical analyses, product development and other lawful, non-Plan related purposes. Such Plan Records will be kept by Aetna for a minimum of seven years, unless Aetna turns such documentation over to the Customer or a designee of the Customer.

9. CONFIDENTIALITY

(A) Business Confidential Information - Neither party may use “Business Confidential Information” (as defined below) of the other party for its own purpose, nor disclose any Business Confidential Information to any third party. However, a party may disclose Business Confidential Information to that party’s representatives who have a need to know such information in relation to the administration of the Plan, but only if such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them. The Customer shall not disclose Aetna’s provider discount or payment information to any third party, including the Customer’s representatives, without Aetna’s prior written consent and until each recipient has executed a confidentiality agreement reasonably satisfactory to Aetna.

The term “Business Confidential Information” as it relates to the Customer means the Customer identifiable business proprietary data, procedures, materials, lists and systems, but does not include Protected Health Information (“PHI”) as defined by HIPAA or other claims-related information.

The term “Business Confidential Information” as it relates to Aetna means the Aetna identifiable business proprietary data, rates, fees, provider discount or payment information, procedures, materials, lists and systems.

(B) Plan Participant Information - Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business associate agreement associated with this Agreement. The Customer may identify, in writing, certain Customer employees or third parties, who the Plan has authorized to receive Plan Participant-identifiable information from Aetna in connection with Plan administration. Subject to more restrictive state and federal law, Aetna
will disclose Plan Participant-identifiable information to the Customer designated employees or third parties. In the case of a third party, Aetna may require execution by the third party of a non-disclosure agreement reasonably acceptable to Aetna. The Customer agrees that it will only request disclosure of PHI to a third party or to designated employees if: (i) it has amended its Plan documents, in accordance with 45 CFR 164.314(b) and 164.504(f)(2), so as to allow the Customer designated employees or third parties to receive PHI, has certified such to the Plan in accordance with 45 CFR 164.504(f)(2)(ii), and will provide a copy of such certification to Aetna upon request; and (ii) the Plan has determined, through its own policies and procedures and in compliance with HIPAA, that the PHI that it requests from Aetna is the minimum information necessary for the purpose for which it was requested.

(C) Upon Termination - Upon termination of the Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other’s Business Confidential Information in its possession or control except to the extent such Business Confidential Information must be retained pursuant to applicable law or cannot be disaggregated from Aetna’s databases. Aetna may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under this Agreement, for use in the processing of runoff claims for Plan benefits, and for regulatory purposes.

10. AUDIT RIGHTS

The Customer may, at its own expense, audit Plan claim transactions upon reasonable notice to Aetna. The Customer may conduct one audit per year and the audit must be completed within two years of the end of the time period being audited. Audits of any performance guarantees, if applicable, must be completed in the year following the period to which the performance guarantee results apply. Audits must be performed at the location where the Customer’s claims are processed.

The Customer may select its own representative to conduct an audit, provided that the representative must be qualified by appropriate training and experience for such work and must perform the audit in accordance with published administrative safeguards or procedures and applicable law. In addition, the representative must not be subject to an Auditor Conflict of Interest which would prevent the representative from performing an independent audit. An “Auditor Conflict of Interest” means any situation in which the designated representative (i) is employed by an entity which is a competitor of Aetna, (ii) has terminated from Aetna or any of its affiliates within the past 12 months, or (iii) is affiliated with a vendor subcontracted by Aetna to adjudicate claims. If the audit firm is not licensed or a member of a national professional group, or if the audit firm has a financial interest in audit findings or results, the audit agent must agree to meet Aetna’s standards for professionalism by signing Aetna’s Agent Code of Conduct prior to performing the audit. Neither the Customer nor its representative may make or retain any record of provider negotiated rates or information concerning treatment of drug or alcohol abuse, mental/nervous, HIV/AIDS or genetic markers.

The Customer shall provide reasonable advance notice of its intent to audit and shall complete an Audit Request Form providing information reasonably requested by Aetna. No audit may commence until the Audit Request Form is completed and executed by the Customer, the auditor and Aetna. Further, the Customer or its representative shall provide Aetna with a complete listing of the claims chosen for audit at least four weeks prior to the on-site portion of the audit.

The Customer’s auditors shall provide their draft audit findings to Aetna, prior to issuing the final report. This draft will provide the basis for discussions between Aetna and the auditors to resolve and finalize any open issues. Aetna shall have a right to review the auditor’s final Audit Report, and include a supplementary statement containing information and material that Aetna considers pertinent to the audit.

Additional guidelines related to the scope of the audit are included in the applicable schedules.

11. RECOVERY OF OVERPAYMENTS

Aetna shall reprocess any identified errors in Plan benefit payments (other than errors Aetna reasonably determines to be de minimis) and seek to recover any resulting overpayment by attempting to contact the party.
receiving the overpayment twice by letter, phone, or email. The Customer may direct Aetna not to seek recovery of overpayments from Plan Participants, in which event Aetna will have no further responsibility with respect to those overpayments. The Customer shall reasonably cooperate with Aetna in recovering all overpayments of Plan benefits.

If Aetna elects to use a third-party recovery vendor, collection agency, or attorney to pursue the recovery, the overpayment recoveries will be credited to the Customer net of fees charged by Aetna or those entities.

Any requested payment from Aetna relating to an overpayment must be based upon documented findings or direct proof of specific claims, agreed to by both parties, and must be due to Aetna’s actions or inactions. Indirect or inferential methods of proof – such as statistical sampling, extrapolation of error rate to the population, etc. – may not be used to determine overpayments. In addition, use of software or other review processes that analyze a claim in a manner different from the claim determination and payment procedures and standards used by Aetna shall not be used to determine overpayments.

When seeking recovery of overpayments from a provider, Aetna has established the following process: if it is unable to recover the overpayment through other means, Aetna may offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. Aetna may reduce future payments to the provider (including payments made to that provider involving the same or other health and welfare plans that are administered by Aetna) by the amount of the overpayment, and Aetna will credit the recovered amount to the plan that overpaid the provider. By entering into this Agreement, the Customer is agreeing that its right to recover overpayments shall be governed by this process and that it has no right to recover any specific overpayment unless otherwise provided for in this Agreement.

The Customer may not seek recovery of overpayments from network providers, but the Customer may seek recovery of overpayments from other third parties once the Customer has provided Aetna notice that it will seek such recovery and Aetna has been afforded a reasonable opportunity to recover such amounts. Aetna has no duty to initiate litigation to pursue any overpayment recovery. Customer agrees to comply with all of the applicable terms of Aetna’s network provider contracts.

12. INDEMNIFICATION

(A) Aetna shall indemnify the Customer, its affiliates and their respective directors, officers, and employees (only as employees, not as Plan Participants) for that portion of any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys’ fees) (“Losses”) caused directly by (i) any material breach of this Agreement by Aetna, including a failure to comply with the standard of care in section 3; (ii) Aetna’s negligence, willful misconduct, fraud, or breach of fiduciary responsibility; or (iii) Aetna’s infringement of any U.S. intellectual property right of a third party, arising out of the Services provided under this Agreement.

(C) The party seeking indemnification under this Agreement must notify the indemnifying party within 20 days in writing of any actual or threatened action, to which it claims such indemnification applies. Failure to so notify the indemnifying party will not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice as indicated above.

The indemnifying party may join the party seeking indemnification as a party to such proceeding; however the indemnifying party shall provide and control the defense and settlement with respect to claims to which this section applies.

(C) The Customer and Aetna agree that: (i) health care providers are not the agents or employees of the Customer or Aetna and neither party renders medical services or treatments to Plan Participants; (ii) health care providers are solely responsible for the health care they deliver to Plan Participants, and neither the Customer nor Aetna is responsible for the health care that is delivered by health care providers; and (iii) the indemnification obligations of (A) or (B) above do not apply to any portion of any loss relating to the acts or omissions of health care providers with respect to Plan Participants.
(D) These indemnification obligations above shall not apply to any claims caused by (i) an act, or failure to act, by one party at the direction of the other, or (ii) with respect to intellectual property infringement, the Customer's modification or use of the Services or materials that are not contemplated by this Agreement, unless directed by Aetna, including the combination of such Services or materials with services, materials or processes not provided by Aetna where the combination is the basis for the claim of infringement. For purposes of the exclusions in this paragraph, the term "Customer" includes any person or entity acting on the Customer's behalf or at the Customer's direction. For purposes of (A) and (B) above, the standard of care to be applied in determining whether either party is "negligent" in performing any duties or obligations under this Agreement shall be the standard of care set forth in section 3.

13. DEFENSE OF CLAIM LITIGATION

In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for Plan benefits, the party designated in this document as the fiduciary which rendered the decision in the appeal last exercised by the Plan Participant which is being appealed to the court ("appropriate named fiduciary") shall undertake the defense of such action at its expense and settle such action when in its reasonable judgment it appears expedient to do so. If the other party is also named as a party to such action, the appropriate named fiduciary will defend the other party PROVIDED the action relates solely and directly to actions or failure to act by the appropriate named fiduciary and there is no conflict of interest between the parties. The Customer agrees to pay the amount of Plan benefits included in any judgment or settlement in such action. The other party shall not be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent provided in section 12 (Indemnification).

Notwithstanding anything to the contrary in this section 13, in any multi-claim litigation disputing reimbursement for benefits for more than one Plan Sponsor, the Customer authorizes Aetna to defend and reasonably settle the Customer's benefit claims in such litigation.

14. REMEDIES

Other than in an action between the parties for third party indemnification, neither party shall be liable to the other for any consequential, incidental or punitive damages whatsoever.

15. COMPLIANCE WITH LAWS

Aetna shall comply with all applicable federal and state laws including, without limitation, the Patient Protection and Affordable Care Act of 2010 ("PPACA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Employee Retirement Income Security Act of 1974 ("ERISA").

16. TERMINATION

This Agreement may be terminated by Aetna or the Customer as follows:

(A) Termination by the Customer – The Customer may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving Aetna at least 90 days’ prior written notice of when such termination will become effective.

(B) Termination by Aetna and Suspension of Claim Payments-

(1) Aetna may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving the Customer at least ninety (90) days’ prior written notice of when such termination will become effective.
(2) If the Customer fails to fund claim wire requests from Aetna, or fails to pay Service Fees by the Payment Due Date, Aetna has the right to cease paying claims and suspend Services until the requested funds or Service Fees have been provided. Aetna may terminate the Agreement immediately upon notice to the Customer if the Customer fails to fund claim wire requests or pay the applicable Service Fees in full within (15) fifteen days of written notice by Aetna.

(C) **Legal Prohibition** - If any jurisdiction enacts a law or Aetna reasonably interprets an existing law to prohibit the continuance of the Agreement or some portion thereof, the Agreement or that portion shall terminate automatically as to such jurisdiction on the effective date of such law or interpretation; provided, however, if only a portion of the Agreement is impacted, the Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

(D) **Responsibilities on Termination** –
Upon termination of the Agreement, for any reason other than default of payment by the Customer, Aetna will continue to process runoff claims for Plan benefits that were incurred prior to the termination date, which are received by Aetna within 12 months following the termination date. The Service Fee for such activity is included in the Service Fees described in the Service and Fee Schedule(s). Runoff claims will be processed and paid in accordance with the terms of this Agreement. New requests for benefit payments received after the 12-month runoff period will be returned to the Customer or to a successor administrator at the Customer’s expense. Claims which were pending or disputed prior to the start of the runoff period will be handled to their conclusion by Aetna, as well as provider performance or incentive payments paid for prior period performance pay outs, and Customer agrees to fund such claims or payments when requested by Aetna.

The Customer shall continue to fund Plan benefit payments and agrees to instruct its bank to continue to make funds available until all outstanding Plan benefit payments have been paid or until such time as mutually agreed upon by Aetna and the Customer. The Customer’s wire line and bank account from which funds are requested must remain open for one year after runoff processing ends, or two years after termination.

Upon termination of the Agreement and provided all Service Fees have been paid, Aetna will release to the Customer, or its successor administrator, all claim data in Aetna’s standard format, within a reasonable time period following the termination date. All costs associated with the release of such data shall be paid by the Customer.

17. **GENERAL**

(A) **Relationship of the Parties** - The parties to this Agreement are independent contractors. This Agreement is not intended and shall not be interpreted or construed to create an association, agency, joint venture or partnership between the parties or to impose any liability attributable to such a relationship. Each party shall be solely responsible for all wages, taxes, withholding, workers compensation, insurance and any other obligation on behalf of any of its employees,

(B) **Intellectual Property** - Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under this Agreement (the “Aetna IP”). Aetna has granted the Customer a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Agreement. Customer agrees not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in this Agreement shall be deemed to grant any additional ownership rights in , or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to the Customer.

(C) **Communications** - Aetna and the Customer may rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties. For a notice or other communication under this Agreement to be valid, it must be in writing and delivered (i) by hand, (ii) by e-mail or (iii) by fax to a representative of each party as mutually agreed upon. Notices or communications may also be sent by U.S. mail to the address below.

Master Services Agreement – Dental Services 7 10.18.2019
If to Aetna:

Justin Remick - Head of Government Programs
Aetna International
151 Farmington Ave
Hartford, CT 06105

If to the Customer:

Director
Department of Administration Government of Guam
590 S. Marine Corps Dr., Ste. 224
Tamuning, Guam 96913

(D) Force Majeure – With the exception of the Customer’s obligation to fund benefit payments and Service Fees, neither party shall be deemed to have breached this Agreement, or be held liable for any failure or delay in the performance of any portion of its obligations under this Agreement, including performance guarantees if applicable, if prevented from doing so by a cause or causes beyond the reasonable control of the party. Such causes include, but are not limited to: acts of God; acts of terrorism; pandemic; fires; wars; floods; storms; earthquakes; riots; labor disputes or shortages; and governmental laws, ordinances, rules, regulations, or the opinions rendered by any court, whether valid or invalid.

(E) Governing Law - The Agreement shall be governed by and interpreted in accordance with applicable federal law, including ERISA. To the extent such federal law does not govern, the Agreement shall be governed by Guam law.

(F) Financial Sanctions – If Plan benefits or reimbursements provided under this Agreement violate or will violate any economic or trade sanctions, such Plan benefits or reimbursements are immediately considered invalid. Aetna cannot make payments for claims or Services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written office of Foreign Assets Control (OFAC) license.

(G) Waiver - No delay or failure of either party in exercising any right under this Agreement shall be deemed to constitute a waiver of that right.

(H) Third Party Beneficiaries - There are no intended third-party beneficiaries of this Agreement.

(I) Severability – If any provision of this Agreement or the application of any such provision to any person or circumstance shall be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement and all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect.

(J) Entire Agreement; Order of Priority - This Agreement, and the accompanying HIPAA business associate agreement, constitutes the entire understanding between the parties with respect to the subject matter of this Agreement, and supersedes all other agreements, whether oral or written, between the Parties.

(K) Amendment – No modification or amendment of this Agreement will be effective unless it is in writing and signed by both Parties, except that a change to a party’s address of record as set forth in section 18(C) (Communications) may be made without being countersigned by the other party.

(L) Assignment - This Agreement may not be assigned by either party without the written approval of the other party. The duties and obligations of the parties will be binding upon, and inure to the benefit of, successors, assigns, or merged or consolidated entities of the parties.

(M) Survival - Sections 5, 8 through 13 and 17(D) shall survive termination of the Agreement.

The parties are signing this agreement as of the date stated in the introductory clause.
GOVERNMENT OF GUAM

Edward M. Birn, Director
Department of Administration
Date: October 19, 2019

Dafne Shimizu, Acting Ins. Commissioner
Department of Revenue and Taxation
Date: 11/21/19

CLEARED PER BBMR’S REVIEW

Lester Carlson, Director
Bureau of Budget Management Research
Date: DEC 02, 2019

Approved as to Legality and Form

Leevin Cantanot Camacho, Attorney General of Guam
Office of the Attorney General
Date: 12/6/19

Approved

Honorable Lourdes A. Leon Guerrero
Governor of Guam
Date: 12/10/19

AETNA LIFE INSURANCE COMPANY:

By: Karen A. Lynch

Name: Karen A. Lynch
Title: President, Aetna

DEPARTMENT OF ADMINISTRATION
DIVISION OF ACCOUNTS

Registration Date 12/16/19
Registration No. 82006001
Vendor No. 900000001
Registered By: 12/18/2019

Master Services Agreement – Dental Services

10.18.2019
EXHIBIT 1
DENTAL SERVICE SCHEDULE

Subject to the terms and conditions of the Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4 of the Agreement) will be provided by Aetna. Additional Services may be provided at the Customer’s written request under the terms of the Agreement. This Schedule shall supersede any previous documents describing the Services.

I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under ERISA necessarily involves the exercise of discretion on Aetna’s part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

II. ADDITIONAL AUDIT GUIDELINES

Aetna is not responsible for paying the Customers’ audit fees or the costs associated with an audit. Aetna will bear its own expenses associated with an audit; provided (i) the on-site portion of the audit is completed within five days, and (ii) the sample size is no more than 250 claims. Aetna will notify the Customer prior to the audit, if an audit request would require an additional payment from the Customer for any audits in excess of the aforementioned thresholds.

III. DENTAL MANAGEMENT SERVICES:

1. Dental Utilization Management:

The Dental utilization management program provides for appropriate review, by licensed dentists and other dental professionals, of certain dental claims, as well as of voluntary predeterminations, in order to assist in making coverage determinations based on the necessity and appropriateness of services rendered to treat Plan Participants’ dental conditions.

2. Dental/Medical Integration (DMI) Program:

The DMI program is designed to educate Plan Participants on the impact of good oral health care on the management of certain diseases and conditions. Plan Participants identified with diabetes, coronary artery disease/cerebrovascular disease or who are pregnant, are sent educational materials explaining the correlation between their disease or condition and periodontal disease. The following programs are included:

- Enhanced Benefit Program for Pregnant Women (offers additional benefits, i.e., an additional cleaning).
- Enhanced Benefit Program for Diabetes and Coronary Artery Disease (offers additional benefits, i.e., an additional cleaning).
- Member Outreach Program (educational materials sent to Plan Participants or outreach phone calls made to Plan Participants encouraging the importance of oral care).
IV. TECHNOLOGY/WEB TOOLS

1. DocFind®

Aetna’s online participating provider directory—updated daily— that anyone can use to locate network physicians and other health care providers such as dentists, optometrists, hospitals and pharmacies.

2. Aetna Navigator®/Health Hub

Aetna Navigator®/Health Hub is a secure Employee website that can be used as an online resource for personalized health and financial information.

V. ID CARDS

Dental ID cards are not required to obtain dental services; therefore, Aetna does not mail ID cards to Plan Participants. However, Plan Participants can print their card by going to their secure website at www.aetna.com.

Upon the Customer’s request, Aetna will include third-party vendor information on Plan Participant identification cards. In such event, the Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees from that portion of any actual third-party loss (including reasonable attorney’s fees) resulting from the inclusion of such third-party vendor information on identification cards.

VI. DENTAL SAVINGS PROGRAMS

1. DENTAL PPO NETWORK PROGRAM (PPO).

PPO dental Providers are considered participating providers in the Customer’s Plan, and Covered Services rendered by such Providers will be paid as in-network services in accordance with the terms of the Customer’s Plan. When available, the Contracted Rates with PPO Providers may result in savings for the Customer and Plan Participants. Aetna contracts with one or more third-party network vendors to access their Contracted Rates with Providers. The Providers have agreed to accept the Contracted Rate and not to balance bill Plan Participants.

2. Terms and Conditions Applicable to Both Programs

A. Customer Charges For Provider Payments

For Plan benefits rendered by a Provider for which Aetna has accessed a Contracted Rate, the Customer shall be charged the amount paid to the Provider, less any applicable coinsurance and/or deductible owed by the Plan Participant under the Plan.

B. Access Fees

(i) As compensation for the services provided by Aetna under either program for Savings achieved, the Customer shall pay an Access Fee to Aetna as described in the Service and Fee Schedule (excluding Savings with respect to claims for which Aetna is liable for funding, e.g., claims in excess of an individual or aggregate stop loss point).

(ii) Aetna shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports.
C. Plan Participant Information Regarding the Programs
The Customer is responsible for informing Plan Participants of the availability of the programs.

D. Definitions

As used in this section VI:

"Access Fee" means the amount to be paid by the Customer to Aetna for access to the Savings provided under the program, as indicated in the Service and Fee Schedule.

"Contracted Rate" means the amount the Provider has agreed to accept as payment under the Provider’s contract with a third party network vendor.

"Provider" means those dentists and other dental care providers who have agreed pursuant to a contract with a third-party network vendor to provide Plan benefits at a Contracted Rate under the program.

"Recognized Charge" is defined in the Customer’s Plan. Where a similar term (such as “reasonable charge amount”) is used in the Customer’s Plan instead of “recognized charge”, it will have the same meaning as Recognized Charge.

"Savings" means: the difference between the average charges for the area as identified in the FAIR Health claims database and the Contracted Rate. For any Plan benefit where the Recognized Charge is lower than the Contracted Rate, the Savings will be zero.

The Customer acknowledges that:

(i) Aetna does not credential, monitor or oversee those Providers who participate through third-party contracts; such providers may not necessarily be available or convenient.

(ii) Information about participating PPO Providers can be found on DocFind®, Aetna’s online provider listing, on our website at www.Aetna.com or by other comparable means. PPO Providers listed on DocFind may not necessarily be available or convenient.

(iii) The following claim situations may not be eligible for either program:
  • Claims involving Medicare when Aetna is the secondary payer
  • Claims involving coordination of benefits (COB) when Aetna is the secondary payer

E. General Provisions

(i) Aetna’s only liability to the Customer for any loss of access to a discount arising under or related to either program, regardless of the form of action, shall be limited to the Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

(ii). The terms and conditions of either program shall remain in effect for any claims incurred prior to the termination date that are administered by Aetna after the termination date.
EXHIBIT 2
SERVICE AND FEE SCHEDULE

The Service Fees and Services effective for the period beginning October 1, 2019 and ending September 30, 2020 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to “Member” shall mean a Plan Participant as defined in the Agreement.

<table>
<thead>
<tr>
<th>Product</th>
<th>Per Employee* Per Month Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Dental</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

* A person within classes that are specifically described in Appendix I, including employees, retirees, and any other persons including those of subsidiaries and affiliates of Customer who are reported, in writing, to Aetna for inclusion in the Services Agreement.

<table>
<thead>
<tr>
<th>Services</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dental Utilization Management</td>
<td></td>
</tr>
<tr>
<td>• DocFind&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>• Aetna Navigator&lt;sup&gt;®&lt;/sup&gt;/Health Hub</td>
<td></td>
</tr>
</tbody>
</table>

A. Late Payment

If Customer fails to provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fails to pay service fees on a timely basis as provided in such Agreement, Aetna will assess a late payment charge in accordance with Article 5 of Chapter 22 of Title 5 of the Guam Code Annotated.

Aetna reserves the right to collect any incurred late payment charges through the claim wire on a monthly basis provided there is no other special payment arrangements in-force to fund any incurred late payment charges. Customer will be notified by Aetna in writing to obtain approval prior to billing any late payment charges through claim wire.

Aetna will notify Customer of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.
**EXHIBIT 3**  
**DENTAL PLAN OF BENEFITS**

Actna shall administer the Plan(s) consistent with provisions found in the Plan document(s) listed below.

<table>
<thead>
<tr>
<th>Name of Document</th>
<th>Issue Date</th>
<th>Effective Date of Document</th>
<th>Eligible Group and/or Type of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


GOVERNMENT OF GUAM

And

GROUP HEALTH INSURANCE AGREEMENT

October 1, 2019– September 30, 2020

Preamble

This Agreement is made effective by and between the GOVERNMENT OF GUAM ("GovGuam") and AETNA LIFE INSURANCE COMPANY. The effective date of this Agreement is October 01, 2019.

Recitals

WHEREAS, Company is an insurance company duly licensed to do business in Guam; and WHEREAS, Company is qualified to provide a group health insurance program to GovGuam; and

WHEREAS, GovGuam selected Company to provide group health insurance benefits to GovGuam active and retired employees, their dependents, and survivors of retired employees who receive annuity benefits; and

WHEREAS, Company offers group health insurance program benefits, as hereinafter set forth, under a group health insurance plan known as the "Government of Guam Plan", and

WHEREAS, the parties wish to enter into an agreement defining their mutual rights and obligations.

NOW, THEREFORE, in consideration of the premises, mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:
ARTICLE 1

Preamble and Recitals

The preamble and recitals set forth above are hereby incorporated into and made a part of this Agreement.

ARTICLE 2

General Provisions

2.1 Definitions: The following words and phrases shall have the following meanings, unless a different meaning is required by the context. Words in the singular shall include the plural unless the context indicates otherwise. These are general definitions and are not an indication of the existence of a benefit. The definitions shall control the interpretation of this Agreement, Enrollment forms, any identification cards, any supplements and the performance hereunder, unless the term is otherwise specifically defined or modified within a particular section of this Agreement.

2.1.1 Agreement: Shall be defined as this Group Health Insurance Agreement including Exhibits A through D.

2.1.2 Covered Person: Shall be defined as a person entitled to receive Covered Services pursuant to the Plan. A Covered Person shall reside in the Service Area and shall be:

2.1.2.1 a bona fide employee of GovGuam who is classified as a full-time employee by GovGuam; or
2.1.2.2 voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or
2.1.2.3 classified as a retiree of GovGuam by GovGuam; or
2.1.2.4 classified as a survivor of a retired employee of GovGuam by GovGuam; or
2.1.2.5 except as otherwise provided in this Agreement, a dependent as defined under the Plan.

2.1.3 Covered Services: Shall be defined as medically necessary services, as defined under the Plan, that are not specifically excluded from coverage by this Agreement and other Services which are specifically included.

2.1.4 Currency: Shall be defined as money accepted as a medium of exchange for payment of debts such as the United States Dollar in the United States and the Peso in the Philippines.

2.1.5 Deductible: Shall be defined as the amount paid by a Covered Person or Family for Covered Services during a Plan Year before Covered Services shall be paid by the Company under this Agreement. No deductible shall apply to preventive services as defined by PPACA, annual refraction eye exam, primary physician care, specialty care visits, prescription drugs, routine laboratory, urgent care, outpatient executive checkup and routine x-ray.

2.1.6 Domicile: Shall be defined as the place where a person has his or her true, fixed, and permanent home and principal establishment, and to which whenever that person is absent that person has the intention of returning. A person shall have only one domicile at a time.

2.1.7 Eligible Charge(s): Shall be defined as the portion of charges made to a Covered Person for Covered
Services rendered which are payable to the Provider under this Agreement. For a Participating Provider, the Eligible Charges shall be the reimbursement amounts agreed to between the Company and the Participating Provider. For a Non-Participating Provider, the Eligible Charges for covered medical Services rendered by a provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or (c) in Asia, the fees most recently contracted by the Company at St. Luke’s Medical Center, Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.

2.1.8 Enrollment: Shall be defined as the acceptance, as of a specified date, of a written application for coverage under the Plan on forms provided by the Company.

2.1.9 HIPAA: Shall be defined as the Health Insurance Portability and Accountability Act of 1996, as amended (including amendments by PPACA), including all provisions codified at 42 U.S.C. §300gg, and the regulations promulgated thereunder.

2.1.10 Other Plan: Shall be defined as any other health insurance or health benefits program offered to GovGuam’s employees, retirees and their eligible Dependents, through an Agreement with GovGuam.

2.1.11 Participating Providers, Non-Participating Providers, Providers and Network:

2.1.11.1 "Providers" shall be defined as health care providers who are duly licensed in their jurisdiction and acting within the scope of their license. Such term shall include, without limitation, physicians, hospitals, ancillary health Services facilities and ancillary health care providers.

2.1.11.2 "Participating Providers" shall be defined as Providers who: (i) have directly, or indirectly through Company's agreements with other networks, entered into an agreement with the Company to provide the Covered Services; and (ii) are assigned from time to time by the Company to participate in the Network or any other network of Company pursuant to this Agreement.

2.1.11.3 "Network" shall be defined as the network of Participating Providers. Network may also be referred to as "Plan Network".

2.1.11.4 "Non-Participating Provider" shall be defined as Providers who have NOT been contracted by the Company to provide medical or dental services to Covered Persons.

2.1.11.5 Payment of claims to Providers: Claims shall be paid based on the agreements that Company has with its providers whenever the services are rendered by a participating provider; and based on 140% of Medicare allowable rate for non-participating facilities and 105% of Medicare allowable rate for non-participating provider whenever the services are rendered by a non-participating provider.

2.1.12 PHSA: Shall mean the Public Health Service Act provisions that are part of HIPAA (as defined above), some of which have been added to the PHSA by PPACA.
2.1.13 Plan: Shall be defined as the group health insurance benefits provided in accordance with this Agreement.

2.1.14 Plan Year: Shall be defined as the twelve (12) month period during which group health insurance benefits are provided under this Agreement.

2.1.15 PPACA: Shall mean the Patient Protection and Affordable Care Act of 2010, as amended.

2.1.16 Premium: Shall be defined as the dollar amount paid to the Company for the provision of this Plan to Covered Persons, including any contributions required from the Covered Persons.

2.1.17 Services: Shall be defined as medical, dental or other health care services, treatments, supplies, medications and equipment.

2.1.18 Service Area: Shall be defined as Guam and the Commonwealth of the Northern Mariana Islands. Enrollment to this Plan is limited to individuals residing in the Service Area. However, residence in the service area shall not be a requirement for enrollment for dependent children below 26 years of age.

2.1.19 Subscriber: Shall be defined as a Covered Person who is not a dependent as defined under the Plan.

2.2 PPACA Requirements: It is the intent of this Agreement to provide, at a minimum, all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act (Public Law 111-148), and the regulations promulgated under the authority of this Act, except for the benefits, rights and responsibilities as specifically excluded by GovGuam.

2.3 Guaranteed Renewability of Health Insurance Coverage: In the event that GovGuam invokes the protection afforded by the Health Insurance Portability and Accountability Act of 1996, as amended, found at Section 2712 of the Public Health Services Act, and its regulations, for the guaranteed renewability of health insurance coverage the parties agree that coverage would be continued until a new contract is in place with the first ninety (90) days of coverage guaranteed at the same rate and plan designs.

ARTICLE 3

Services

3.1 Company shall provide Covered Persons with the group health insurance benefits, subject to the applicable limitations and conditions, set forth in this Agreement and the Certificate incorporated herein.

ARTICLE 4

Rates, Premiums and Experience Participation

4.1 Rates. Company shall provide the group health insurance benefits set forth in the Certificate for the rates contained herein.

09/10/2019
4.2 Premium Payment. GovGuam shall pay the Premium due under this Agreement to Company within thirty (30) days of receipt of each monthly invoice detailing the current month’s Premium due. Payment in full of all Premiums due constitutes a discharge of GovGuam’s responsibility for the cost of benefits and administration provided under this Agreement. Should GovGuam fail to pay any Premium when due under this Agreement, Company shall have the right to suspend performance under this Agreement with respect to any Covered Person whose Premium payments have not been paid by GovGuam, in addition to the right of termination under Article 5.2.1 and Article 5.3. However, such suspension may only take place after Company provides written notice to GovGuam at least ten (10) days prior to the suspension stating the names of the Covered Persons at risk of suspension and the amount of Premium owed for each. Further, Company shall retroactively reinstate a Covered Person’s right to benefits upon full payment of the past due Premiums only if the premiums are paid within 120 days after the notification of the suspension.

4.3 Experience Participation. No later than April 30, 2021, the Company shall present to GovGuam an annual experience participation accounting, which will produce either a positive or negative balance after accounting for all incurred claims and the 14% of premium guaranteed retention for the Company, such experience participation to be determined as follows,

4.3.1 The term “Target Experience” shall mean the amount calculated by multiplying (a) the total Premiums earned by the Company for the full 12-month Plan Year ending the last day of the fiscal year under the policies issued to the government of Guam with respect to such Plan Year, by (2) a percentage not lower than eighty-six percent (86%); The term "Actual Experience" shall be an amount calculated by subtracting from the Target Experience all claims incurred during such Plan Year and paid in the time period ending six months after the end of the Plan Year by the Health Insurance Provider under all the policies (PPO 1500, HSA 2000, and RSP);

4.3.1.1 Claims are defined as: payments to medical, and pharmacy Providers; gym membership payments; airfare payments

4.3.1.2 Excluded from Claims: network access fees, shared savings or other cost containment programs, wellness incentives other than gym memberships, quality improvement incentives

4.3.1.3 Note: The intent of this the foregoing sections is that wellness and quality improvement incentives, quantifiable and payable directly to the member, will be included as claims in the numerator of the loss ratio calculation. Other general quality improvement activities and other costs are intended to be administrative costs for the carrier and are not to be included in the numerator of this calculation.

4.3.1.4 Subtracted from Claims: pharmacy rebates accrued during the plan year

4.3.1.5 Premiums are calculated as premiums paid in the course of the plan year October 1, 2019 to September 30, 2020: monthly enrollment by Plan and class, multiplied by applicable premium rates by Plan and class. Supporting documentation of this calculation must be provided with the annual statement of reconciliation

4.3.2 The term "Experience Refund" shall be a positive Actual Experience. See Title 4 GCA §4302.3(g). The difference between: 86% of Premiums less Claims will be refunded to the Government.

4.3.3 To the extent the Actual Experience is positive (i.e., an amount greater than zero), such amount will be called an "Experience Refund," and the Company shall remit such amount to GovGuam for placement into
the "Section 2718 Fund" established by Title 4, Guam Code Annotated, Section 4302.3 (P.L. 31-233:XII:18).

4.3.4 To the extent the Actual Experience is negative (i.e., an amount less than zero), the Company may add this amount to the premium needed for the Plan Year beginning on October 1, 2020, but only if the Company is the health insurance provider during such Plan Year.

4.3.5 If PPACA's Minimum Loss Ratio ("MLR") requirements result in payment, from the Company to GovGuam, of a refund for the 2019 calendar year MLR calculations, any Experience Refund calculated above in section 4.3.3, will be reduced by the portion of the MLR refund payable to GovGuam and applicable to the policies. The portion applicable to the policies is determined by multiplying the MLR refund by the ratio of the policies' earned premium in the calendar year to the total of the GovGuam paid premium in that calendar year.

ARTICLE 5

Term and Termination

5.1. Term. The Agreement is for a one-year term beginning October 1, 2019 and ending September 30, 2020, unless terminated for major default in services, given by written notice from GovGuam to Company not less than ninety (90) calendar days or unless modified by mutual agreement.

5.2. Termination:

5.2.1. By Company. If GovGuam fails to make any Premium payment within fifteen (15) days after receipt of a written notice of non-payment from Company, Company may terminate this Agreement by providing at least fifteen (15) days prior written notice of termination to GovGuam and all Subscribers under this Agreement.

5.2.2. Individual termination.

5.2.2.1. Non-payment of Premium. Company may, in accordance with the notice provisions contained in §5.2.1, terminate the coverage of one or more individual Covered Persons for non-payment of Premium without terminating this Agreement as to other Covered Persons for whom Premiums have been received by Company.

5.2.2.2. Other Reasons. Except for non-payment of Premiums, Company may only terminate a Covered Person as provided under the Plan.

5.2.2.3. Review of Termination. Any Covered Person whose coverage is terminated pursuant to this Section 5.3 shall be entitled to a review through the PPACA Claims Procedure set forth in this Agreement, if so requested.

5.3. Effect of Termination. In the event of termination of this Agreement for a Covered Person, Company shall be responsible for providing the benefits contained in this Agreement up to the effective date of termination provided by GovGuam which will not be later than the last day of the pay period for which premium has been remitted. GovGuam shall be responsible for payment of the Premiums up to said effective date.

5.4. Termination of Subscriber's Coverage. If a Subscriber's coverage terminates, the coverage of all of that Subscriber's
Covered Dependents also terminates as of the same date.

ARTICLE 6

Enrollment

6.1 Regular Open Enrollment. The parties to this Agreement shall establish one (1) open Enrollment period, which shall be the same period as for all Other Plans offering health insurance and/or health benefits programs to GovGuam. During such period GovGuam shall provide Company with the assistance and cooperation detailed in Article 8. Except as provided in §6.1.1, §6.2 and §6.3 below, the open Enrollment period is the only time during which current and potential Covered Persons shall be allowed to enroll in this Plan or to disenroll from this Plan. The effective date of such Enrollment or disenrollment shall be the effective date of this Agreement, unless otherwise specified by GovGuam in accordance with this Agreement, or unless otherwise required under HIPAA.

6.1.1 Special Open Enrollments. If GovGuam holds a special open Enrollment during the Plan Year, Company shall participate in such special open Enrollment, unless otherwise agreed by the parties, or unless the Plan is no longer to be offered as of the entry date of the special open Enrollment period. If the special open Enrollment shall impact on rates, the parties shall negotiate an appropriate change prior to the participation of Company in such special open Enrollment.

6.2 Newly Eligible Persons. Subject to §6.3, any individual who becomes a GovGuam employee, or for any other reason first becomes eligible to be a Covered Person outside the open Enrollment period, shall have thirty-one (31) days after the date on which he/she became eligible to become a Covered Person. The effective date of such Enrollment shall be as specified in the applicable Plan certificate.

6.3 Otherwise Eligible. Enrollment shall be restricted to only those occasions provided for in this Article 6 unless an individual is eligible for Enrollment under the HIPAA provisions allowing special enrollment rights. Enrollment shall be in accordance with HIPAA and PPACA requirements.

6.4 Disenrollment Permitted. Covered persons for whom this group health insurance is secondary to Medicare coverage, shall be permitted to disenroll with 30 days’ notice to the Company, and enroll in the Retiree Supplemental Plan.

ARTICLE 7

Company’s Responsibilities

7.1 Marketing. Company shall print and provide necessary brochures, announcements, instructions, Enrollment forms, and certificates for Enrollment purposes and for distribution to potential Covered Persons. Company shall be responsible for the dissemination of information to potential Covered Persons regarding the Plan. Company shall provide agreed upon quarterly communication to members clearly defining the benefits of the current plans in place. Company will work directly with the Government of Guam to determine their needs in distribution, and type of communication desired.

7.2 Benefits to be Provided. Company shall, in consideration of receipt of applicable Premiums, provide the benefits contained in this Agreement through the earlier of the effective date of a Covered Person’s termination or the termination of this Agreement.

09/10/2019
7.3 Financial and Medical Cost Information. In accordance with Title 4 GCA, Section 4302 (b) and (g), Company shall provide GovGuam detailed claims utilization and cost information, and shall provide upon reasonable request, the most recent audited financial statements, experience data, and any other information pertaining to this Agreement.

7.4 Confidential Information. The parties hereto shall maintain the confidentiality of any and all medical records which shall be in their possession and control, and such information shall only be released or disseminated pursuant to the valid authorization of the Covered Person whose medical condition is reflected in such medical records or as shall be otherwise permitted under applicable law. Upon request and subject to applicable law, Company shall make available to GovGuam medical records to assure Covered Persons are receiving adequate and appropriate benefits in accordance with the Certificate.

7.5 Errors and Omission Insurance. The Company shall use all reasonable efforts to secure and maintain current errors and omission liability insurance of at least One Million Dollars ($1,000,000) during the term of this Agreement.

7.6 Payment of Claims. Company shall pay claims in accordance with the Guam Health Care Prompt Payment Act of 2000 and the applicable claims payment requirements of PPACA. Appeals of claim denials shall comply with applicable requirements of PPACA Section 2719 and regulations thereto on internal claims appeal process and external appeals process review requirements.

7.7 Prompt Payment Report. Company shall send a status report on a claim filed by Covered Person against a Provider within forty-five (45) days after receipt if the claim is still pending disposition by the Company and Provider. At a minimum the report shall indicate that the claim is under review and the Company is working to resolve the claim with the Provider. The Company shall send another status report on the claim to the Covered Person with a copy to the Provider thirty (30) days from the date the first status report was sent to the Covered Person if the claim has not been resolved.

7.8 Notification. Company shall fulfill the notice requirements of the Women's Health and Cancer Rights Act of 1998, and the Newborns' and Mothers' Health Protection Act of 1996, and shall be responsible for notice requirements applicable to PPACA requirements.

7.9 Termination Notification. If the Company terminates this Agreement, Company shall provide notice announcing its termination at least fifteen (15) days prior to the date of termination on the Company’s website, an ad in any of the local newspaper publications, and email to subscribers of the Company’s Plan. Further, Company shall fully cooperate with GovGuam in transitioning Covered Persons to Other Plans.

7.10 Sole Source Provider. If there is a Covered Service which is provided on Guam by only one provider who is not a Participating Provider, the eligible Charges for such services shall be as if the sole source provider were a participating provider.

7.11 Online Access Capabilities. The Company shall provide, for the benefit of the Covered Person and GovGuam, the following online access capabilities:

7.11.1 Online access is available twenty-four (24) hours a day, seven (7) days a week in accordance with Section 508 standards of the Rehabilitation Act of 1973 as amended.

7.11.2 For the Covered Person, access to a Personal Claim Record ("PCR"), whichever is applicable to the Company, to include historical health conditions, prescription medications, office visit summary and procedures where a medical claim has been filed.
7.11.3 For the Covered Person, access to record of medical and drug claims.

7.11.4 For the Covered Person, ability to verify eligibility.

7.11.5 Ability of Providers to submit claims through a separate portal rather than through Company's website for payment.

7.11.6 For the Covered Person, GovGuam, and Providers access to Schedule of Benefits, Member Handbooks and Provider Network Information.

7.11.7 For the Covered Person, ability to print PHR or PCR, whichever is applicable to the Company, to federal compliance standard file formats or plain text file.

7.11.8 For the Covered Person, ability to print online membership cards.

7.11.9 For the Covered Person, access to interactive tools for researching health issues, treatments, and risk assessment tools for health conditions.

ARTICLE 8
GovGuam's Responsibilities

8.1 Marketing. GovGuam shall give Company reasonable assistance and cooperation to enable Company to contact all sources of Enrollment, to disseminate all information, to distribute and post literature, to provide access to employees during working hours, to provide all employees' names and addresses, and to instruct department heads to provide Company's representatives reasonable opportunity for personal contact with employees, consistent with that given other GovGuam contracted health plans, for the purpose of explaining Company's Plan to GovGuam employees.

8.2 Responsible Persons. GovGuam shall designate persons within each agency, department and branch, who shall be responsible for the handling of health insurance problems, Enrollment, and cancellations within their particular department. These designated persons shall be available to attend meetings on government time for the purpose of reviewing administrative procedures, and to assist in problem solving relating to this Agreement.

8.3 Personnel Changes. GovGuam shall provide written notice to Company of terminations, resignations, department transfers, and the like, so that coverage can be terminated at the appropriate time. GovGuam shall make available to Company a computer listing of each employee receiving an applicable payroll deduction for Premiums no later than fifteen (15) working days following each pay period.

8.4 Individual with Questionable Status. If GovGuam does not provide the list of employees as required in 8.3, Company shall have the right to charge an individual whose Enrollment is in question for any Covered Services rendered prior to receipt of written verification of eligibility and Enrollment by GovGuam. If such individual is subsequently determined to be a Covered Person, and GovGuam remits a Premium payment for the Covered Person for the period for which the Covered Services were rendered, Company shall cancel all charges to the Covered Person and return any amounts collected. If Company files a written objection to an Enrollment list forwarded by GovGuam, then within thirty (30) days after the filing, GovGuam shall provide Company with the applicable change of status forms, Enrollment cards, and other documentation substantiating the accuracy of the Enrollment records and meet with Company to reconcile any differences. Evaluation of such individual's entitlement shall be handled in accordance with PPACA’s applicable Claims Procedure requirements, taking into account any applicable PPACA prohibition on rescissions and any
applicable PPACA requirement that costs of care be provided or continued during evaluation period.

8.5 No restrictions on Enrollment. GovGuam shall place no restriction or limitation on the percentage or number of Enrollments in the Plan.

ARTICLE 9

Covered Person’s Responsibilities

9.1 Acceptance. By Enrolling in the Plan, all Covered Persons agree to the terms, provisions and conditions of this Agreement.

9.2 Continued Residency. Except as specifically stated in this Agreement, Enrollment in the Plan shall be limited to Covered Persons domiciled in the Service Area, and who do not reside outside the service area for more than one hundred eighty-two (182) days per plan year, Company shall be entitled to require substantiation from a Covered Person to determine the Covered Person’s Domicile and may deny benefits under this Agreement for lack thereof. For a Covered Person Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the one hundred eighty-two (182) day maximum, provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or Spouse of such covered person shall not count toward the one hundred eighty-two (182) day maximum, provided the parent or Spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident of care out of the Service Area.

ARTICLE 10

Notices

10.1 Address of Record. For the purpose of communication and services of notice under this Agreement, the parties’ addresses are as follows:

Aetna Life Insurance Company:                    To: GovGuam
    Justin Remick
    151 Farmington Ave
    Hartford, CT 06105

Director
Department of Administration
Government of Guam
590 S. Marine Corps Dr., Ste.
224 Tamuning, Guam 96913

10.2 Method of Service. Notices shall be in writing and effective upon either receipt of a hand-delivered notice or the posting of notice by first class mail, postage prepaid, to the address listed herein or such other address as a party may designate by providing written notice to the other party from time to time.

ARTICLE 11
Dispute Resolution

11.1 Mandatory Disputes Resolution Clause (As amended but consistent with 2 GAR Div. 4 § 9103(g) and applicable law). GovGuam and the Company agree to attempt resolution of all controversies which arise under, or are by virtue of, this Agreement through mutual agreement. If the controversy is not resolved by mutual agreement, then the Company shall request GovGuam in writing to issue a final decision within sixty days after receipt of the written request. If GovGuam does not issue a written decision within sixty days after written request for a final decision, or within such longer period as may be agreed upon by the parties, then the Company may proceed as though GovGuam had issued a decision adverse to the Company. GovGuam shall immediately furnish a copy of the decision to the Company, by certified mail with a return receipt requested, or by any other method that provides evidence of receipt. GovGuam’s decision shall be final and conclusive, unless fraudulent or unless the Company appeals the decision. This subsection applies to appeals of GovGuam’s decision on a dispute. For money owed by or to GovGuam under this Agreement, the Company shall appeal the decision in accordance with the Government Claims Act by initially filing a claim with the Office of the Attorney General no later than eighteen months after the decision is rendered by GovGuam or from the date when a decision should have been rendered. For all other claims by or against GovGuam arising under this Agreement, the Office of the Public Auditor has jurisdiction over the appeal from the decision of GovGuam. Appeals to the Office of the Public Auditor must be made within sixty days of GovGuam’s decision or from the date the decision should have been made. The Company shall exhaust all administrative remedies before filing an action in the Superior Court of Guam in accordance with applicable laws. The Company shall comply with GovGuam’s decision and proceed diligently with performance of this Agreement pending final resolution by the Superior Court of Guam of any controversy arising under, or by virtue of, this Agreement, except where the Company claims a material breach of this Agreement by GovGuam. However, if GovGuam determines in writing that continuation of services under this Agreement is essential to the public’s health or safety, then the Company shall proceed diligently with performance of the Agreement notwithstanding any claim of material breach by GovGuam.

ARTICLE 12

Governing Law

12.1 The rights and responsibilities of the parties and their respective officers, directors, employees, agents and representatives under this Agreement and their performance hereunder shall be governed by the laws of Guam.

ARTICLE 13

Miscellaneous

13.1 Government Laws and Regulation. Company guarantees the negotiated rates shall remain in effect for the Plan Year. However, if during such year the Government of the United States or GovGuam enacts statutes or promulgates regulations which (i) require that the Company offer different coverage to Covered Persons than that specifically provided in this Agreement; or (ii) causes an increase or decrease in Provider rates or other costs, the parties reserve the right on thirty (30) days written notice to the other to adjust the Premiums if the parties mutually determine that such mandate or law shall change Company’s costs under this Agreement by more than five percent (5%). Where the Agreement indicates that a PPACA requirement might override a specific limitation, this section 13.1 shall apply if it is determined that a PPACA override is in fact required.
13.2 Contingent Fee Warranty. Company warrants that it has not retained anyone to solicit or secure this Agreement for payment of a commission, percentage, brokerage, or contingent fee, except for Company's bona fide employees or any bona fide established commercial selling agencies which Company may disclose to GovGuam.

13.3 Gratuities Warranty. Company warrants that it has not violated, is not violating, and promises it shall not violate the prohibitions against gratuities and kickbacks set forth in Guam Procurement Regulations at Title 2, GAR, Div. 4 §11107.

13.4 Personal Interest Disclaimer. Company warrants that no member of any governing body of any agency of GovGuam and no officer, employee, or agent of GovGuam who exercises any functions or responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement, except that such members, officers or employees may be Covered Persons under the Plan. Company further warrants that no member of the Guam Legislature and no other official of GovGuam who exercises functions and responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement except as possible Covered Persons under the Plan.

13.5 Captions. The captions, section numbers and article numbers and marginal notes appearing in this Agreement or in any copies of this Agreement are placed there only as a matter of convenience and in no way define, limit, or describe the scope or intent of this Agreement.

13.6 Waiver. The waiver of any breach of this Agreement by either party shall not be deemed a waiver of any other breach or a waiver of any subsequent breach of the same nature.

13.7 Excused Non-Performance. The parties’ performance hereunder shall be excused when the failure of performance is caused by fire, explosion, acts of God, civil disorder, war, riot or other event not reasonably within the control of the party.

13.8 Entire Agreement. This Agreement, including and Exhibits A through D, is the entire Agreement between the parties. There are no terms or obligations other than those contained herein applicable to this Agreement. This instrument shall supersede all previous communications or representations, whether verbal or written between the parties.

13.9 Amendment. This Agreement may only be amended upon the written consent of both parties.

13.10 Time of Essence. Time is expressly made of the essence in this Agreement and for performance hereunder.

13.11 Limitation of Actions. Any action in relation to this Agreement must be brought no later than one (1) year from the time such claim arises or should have been reasonably discovered.

13.12 Third Party Rights. Nothing in this Agreement, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to this Agreement and their respective successors and assigns.

13.13 Successors in Interest. Each and all of the covenants, conditions, and restrictions in this Agreement shall inure to the benefit of and shall be binding upon the assignees and successors in interest of Company. However, Company shall not be entitled to assign its interest in this Agreement, or any prior or future agreement with GovGuam, without the express written consent of GovGuam.
13.14 **Severability.** If any term or provision of this Agreement or the application thereof shall to any extent be determined to be invalid or unenforceable, the remainder of this Agreement or the application of such remainder, other than as held invalid or unenforceable, shall not be affected and each term and condition of this Agreement shall be valid and be enforceable to the fullest extent permitted by law.

13.15 **Counterparts.** This Agreement, including Exhibits A through D, may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.

13.16 **Legal Compliance.** Company shall comply with applicable federal and local statutes and regulations, including the certification requirements of HIPAA and applicable requirements of PPACA and the PHSA. To the extent not preempted by the laws of the United States, this Agreement will be construed in accordance with and governed by the laws of Guam. In the event of conflict between any provision of this Agreement and applicable law, the law shall govern.

13.17 **Determination of Currency Exchange Payments.** When a service is rendered outside of the United States, the claims shall be paid in accordance with Company’s agreements with its participating providers. Claims for nonparticipating providers will be reimbursed using the Philippines fees as a reference. Additionally, claims incurred outside of the United States will be based on the date of service and will be converted according to the conversion rate, for cash transactions, against the U.S. Dollar as found in XE.Com and for credit card transactions, against the utilized specific conversion rate for the card used. For multiple dates of service, the rate will be calculated based on the last date of service or payment, whichever is earlier in time.

13.18 **Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues.** The Company warrants that no person convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated, or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated, in Guam, or an offense in any jurisdiction which includes, at a minimum, all of the elements of said offenses, or who is listed on the Sex Offender Registry, shall work for the Company on property of the government of Guam other than a public highway. Further, the Company warrants that if any person providing services on behalf of the Company is convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated or an offense in another jurisdiction with, at a minimum, the same elements as such offenses, or who is listed on the Sex Offender Registry, that such person will be immediately removed from working at such agency and that the administrator of said agency be informed of such within twenty-four (24) hours of such conviction.

13.19 **Ethical Standards.** With respect to this Agreement and any other contract the Company may have, or wish to enter into, with any government of Guam agency, Company represents that it has not knowingly influenced, and promises that it will not knowingly influence, any government employee to breach any of the ethical standards set forth in the Guam Procurement Law and in any of the Guam Procurement Regulations.

13.20 **Minimum Wages As Determined by U.S. Government.** Company agrees to comply with Title 5, Guam Code Annotated, Sections 5801 and 5802. In the event that Company employs persons whose purpose, in whole or in part, is the direct delivery of service contracted by the Government, then the Company shall pay such employees, at a minimum, in accordance with the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Mariana Islands in effect on the date of this Agreement. In the event that this Agreement is renewed by the Government and the Contractor, at the time of the renewal, Company shall pay such employees in accordance with the Wage Determination for Guam and the Commonwealth of the Northern Mariana Islands promulgated on a date most recent to the renewal date. Company agrees to provide employees...
whose purpose, in whole or in part, is the direct delivery of service contracted by the Government those mandated health and similar benefits having a minimal value as detailed in the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands, and guarantee such employees a minimum of ten (10) paid holidays per annum per employee.

**SIGNATURE PAGE Follows**
IN WITNESS WHEREOF, GovGuam and Company have signed this Agreement on the aforementioned date.

Aetna Life Insurance Company

Signed: ____________________________
Title: Executive Director and Head of Government Programs
Name: Justin Remick
Date: 10/11/2019

Government of Guam

Signed: ____________________________
Edward M. Birn, Director
Department of Administration
Date: October 16, 2019

Signed: ____________________________
Dafne Shimizu, Acting Insurance Commissioner
Department of Revenue & Taxation
Date: 1/2/2019

Signed: ____________________________
Lester Carlson, Director
Bureau of Budget and Management Research
Date: DEC 07, 2019

Approved as to Legality and Form

Signed: ____________________________
Leevin Taitano Camacho, Attorney General of Guam
Office of the Attorney General
Date: 12/16/2019

Signed: ____________________________
The Honorable Lourdes A. Leon Guerrero
Governor of Guam
Date: 12/16/2019

Bureau of Budget and Management Research

Proprietary
Preferred provider organization (PPO) medical plan

Certificate of coverage
Prepared exclusively for:
Policyholder: Government of Guam
Policyholder number: 142939
Plan name: Certificate-1/PPO 1500
Group policy effective date: October 1, 2019
Plan effective date: October 1, 2019
Plan issue date: October 1, 2019

Underwritten by Aetna Life Insurance Company

aetna
# TABLE OF CONTENTS

Welcome ........................................................................................................................................... 3
Coverage and exclusions ......................................................... Error! Bookmark not defined.
General plan exclusions ................................................................. 25
How your plan works .......................................................................................... 30
Complaints, claim decisions and appeal procedures ......................... 40
Eligibility, starting and stopping coverage ........................................ 43
General provisions – other things you should know ............................. 46
Glossary ........................................................................................................ 50

Schedule of benefits Issued with your certificate of coverage
Welcome

At Aetna, your health goals lead the way, so we’re joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it’s our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction
This is your certificate of coverage or “certificate.” It describes your covered services – what they are and how to get them. The schedule of benefits tells you how we share expenses for covered services and explains any limits. Along with the group policy, they describe your Aetna plan. Each may have amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It’s really important that you read the entire certificate and your schedule of benefits. You can return them to us, within 30 days, if you are not happy with the coverage. When you do, we will cancel coverage as of your start date. We’ll also refund any premium contribution minus any benefits that have been paid. This doesn’t apply to transferred business. See the Effect of prior coverage.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the General coverage provisions section of the schedule of benefits.

If you need help or information, see the Contact us section below.

How we use words
When we use:
• “You” and “your” we mean you and any covered dependents (if your plan allows dependent coverage)
• "Us," “we,” and “our” we mean Aetna
• Words that are in bold, we define them in the Glossary section

Contact us
For questions about your plan, you can contact us by:
• Calling the toll-free number on your ID card
• Logging in to the Aetna website at https://www.aetnainternational.com/
• Writing us at 151 Farmington Ave, Hartford, CT 06156

Your member website is available 24/7. With your member website, you can:
• See your coverage, benefits and costs
• Print an ID card and various forms
• Find a provider, research providers, care and treatment options
• View and manage claims
• Find information on health and wellness

Your ID card
Show your ID card each time you get covered services from a provider. Only members on your plan can use your ID card. We will mail you your ID card. If you haven’t received it before you need covered services, or if you lose it, you can print a temporary one using the Aetna website.
Wellness and other rewards
You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your provider about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to copayment, deductible or coinsurance amounts
- Contributions to your health savings account
- Merchandise
- Coupons
- Gift or debit cards
- Any combination of the above

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 and 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 their services and discounted goods.
Coverage and exclusions

Your plan provides **covered services**. These are:
- Described in this section.
- Not listed as an exclusion in this section or the *General plan exclusions* section.
- Not beyond any limits in the schedule of benefits.
- **Medically necessary.** See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information.

For **covered services** under the outpatient prescription drug plan:
- You need a **prescription** from the prescribing provider
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

This plan provides insurance coverage for many kinds of **covered services**, such as a doctor’s care and hospital stays, but some services aren’t covered at all or are limited. For other services, the plan pays more of the expense.

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 service** only up to a set number of visits a year. This is a limitation.
- **Your provider** may recommend services that are considered experimental or investigational services. But an experimental or investigational service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a terminal illness. See *Clinical trials* in the list of services below.

Some services require **precertification** from us. For more information see the *How your plan works – Medical necessity and precertification requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you’re looking for. You can find out about limitations for **covered services** in the schedule of benefits. If you have questions, contact us.

**Acupuncture**
**Covered services** include acupuncture services provided by a **physician** if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

The following are not **covered services**:
- Acupuncture, other than for anesthesia
- Acupressure

**Ambulance services**
An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

**Emergency**
**Covered services** include emergency transport to a **hospital** by a licensed ambulance:
- To the first hospital to provide **emergency services**
- From one **hospital** to another if the **hospital** can’t provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport
Non-emergency

Covered services also include precertified transportation to a hospital by a licensed ambulance:
- 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; limited to 100 miles
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not covered services:
- Non-emergency airplane transportation by an out-of-network provider
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain 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
- Are responsible for observable improvements in behavior

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.

Covered services include services and supplies provided by a physician or behavioral health provider for:
- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered services:
- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a provider under an “approved clinical trial” only when you have cancer or a terminal illness. All of the following conditions must be met:
- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:
- The Food and Drug Administration (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, when this is required
• The clinical trial has been approved by an institutional review board that will oversee it
• The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  – It conforms to standards of the NCI or other applicable federal organization
  – It takes place at an NCI-designated cancer center or at more than one institution
• You are treated in accordance with the procedures of that study

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Covered services include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered services:
• Services and supplies related to data collection and record-keeping needed only for the clinical trial
• Services and supplies provided by the trial sponsor for free
• The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

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Covered services include drugs, devices, treatments, or procedures from a provider under an “approved clinical trial” only when you have cancer or a terminal illness. All of the following conditions must be met:
• Standard therapies have not been effective or are not appropriate
• We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:
• The Food and Drug Administration (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, when this is required
• The clinical trial has been approved by an institutional review board that will oversee it
• The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  – It conforms to standards of the NCI or other applicable federal organization
  – It takes place at an NCI-designated cancer center or at more than one institution
• You are treated in accordance with the procedures of that study

Diabetic services, supplies, equipment, and self-care programs
Covered services include:
• Services
  – Foot care to minimize the risk of infection
• Supplies
  – Injection devices including syringes, needles and pens
  – Test strips - blood glucose, ketone and urine
  – Blood glucose calibration liquid
  – Lancet devices and kits
  – Alcohol swabs
• Equipment
  – External insulin pumps and pump supplies
  – Blood glucose monitors without special features, unless required due to blindness
• Prescribed self-care programs with a health care provider certified in diabetes self-care training

Durable medical equipment (DME)
DME and the accessories needed to operate it are:
• Made to withstand prolonged use
• Mainly used in the treatment of 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

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.

Covered services include the expense of renting or buying DME and accessories you need to operate the Item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:
• One item of DME for the same or similar purpose
• Repairing DME due to normal wear and tear
• A new DME item you need because your physical condition has changed
• Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not covered services:
• Communication aid
• Elevator
• Maintenance and repairs that result from misuse or abuse
• Massage table
• Message device (personal voice recorder)
• Over bed table
• Portable whirlpool pump
• Sauna bath
• Telephone alert system
• Vision aid
• Whirlpool

Emergency services
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 help.

Covered services include only outpatient services to evaluate and stabilize an emergency medical condition in a hospital emergency room. You can get emergency services from network providers or out-of-network providers.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the How your plan works – Medical necessity and precertification requirements section and the Coverage and exclusions section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your network physician or primary care physician (PCP).

Non-emergency services
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 for this information.
Habilitation therapy services
Habilitation therapy services 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). The services must follow a specific treatment plan, ordered by your physician. The services must be performed by a:
- Licensed or certified physical, occupational or speech therapist
- Hospital, skilled nursing facility or hospice facility
- Home health care agency
- Physician

Outpatient physical, occupational, and speech therapy
Covered services include:
- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences)

The following are not covered services:
- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids
Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:
- Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist
  - An audiologist who:
    o Is legally qualified in audiology
    o Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    o Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:
- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams
Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing specialist.
The following are not covered services:

- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay

**Home health care**

Covered 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 a stay in a hospital or a skilled nursing facility, or you are unable 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
- 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

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.

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

The following are not covered services:

- Custodial care
- 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**

Covered 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
- Psychological and dietary counseling
- Pain management and symptom control

Hospice care services provided by the providers below will 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

The following are not covered services:
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

Hospital care
Covered services include inpatient and outpatient hospital care. This includes:
- Semi-private room and board. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a hospital, including the facility charge.
- Services of physicians employed by the hospital.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.

The following are not covered services:
- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services
Basic infertility
Covered services include seeing a 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.

The following are not covered services:
- All infertility services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Artificial insemination services.

Maternity and related newborn care
Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, covered services include:
- No less than 48 hours of inpatient care in a hospital after a vaginal delivery
- No less than 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

**Covered services** also include services and supplies needed for circumcision by a provider.

The following are not covered services:
• 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**
**Covered services** include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider including:
• Inpatient room and board at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), 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 disorders
  - Other outpatient mental health treatment such as:
    o Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
    o Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
    o 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
    o Electro-convulsive therapy (ECT)
    o Transcranial magnetic stimulation (TMS)
    o Psychological testing
    o Neuropsychological testing
    o 23 hour observation
    o Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

**Obesity surgery and services**
Obesity surgery is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your physician will determine whether you qualify for obesity surgery.

**Covered services** include:
• An initial medical history and physical exam
• Diagnostic tests given or ordered during the first exam
• Outpatient prescription drugs included under the Outpatient prescription drugs section
• One obesity surgical procedure
• A multi-stage procedure when planned and approved by us
• Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not covered services:
• Weight management treatment
• Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
• Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - 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 surgery (treatment of mouth, jaws and teeth)
Covered services include the following when provided by a physician, a dentist and hospital:

• Surgery needed to:
  - Cut out 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.
• Related dental services are limited to:
  - The first placement of a permanent crown or cap to repair a broken tooth
  - The first placement of dentures or bridgework to replace lost teeth
  - Orthodontic therapy to pre-position teeth

The following are not covered services:
• Services normally covered under a dental plan
• Dental implants

Outpatient surgery
Covered 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, PCP services and not for a separate fee for facilities.

The following are not covered services:
• A stay in a hospital (see Hospital care in this section)
• A separate facility charge for surgery performed in a physician’s office
• Services of another physician for the administration of a local anesthetic

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

• At the physician’s office
- In your home
- In a hospital
- From any other inpatient or outpatient facility
- By way of telemedicine

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

Telemedicine may have a different cost share from other physician services. See your schedule of benefits.

Other services and supplies that your physician may provide:
- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

**Prescription drugs - outpatient**
Read this section carefully. This plan does not cover all prescription drugs and some coverage may be limited. This doesn’t mean you can’t get prescription drugs that aren’t covered; you can, but you have to pay for them yourself. For more information about prescription drug benefits, including limits, see the schedule of benefits.

**Important note:**
A pharmacy may refuse to fill or refill a prescription when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Covered services are based on the drugs in the drug guide. Your cost may be higher if you’re prescribed a prescription drug that is not listed in the drug guide. You can find out if a prescription drug is covered; see the Contact us section.

Your provider can give you a prescription in different ways including:
- A written prescription that you take to a network pharmacy
- Calling or e-mailing a prescription to a network pharmacy
- Submitting the prescription to a network pharmacy electronically

**Prescription drug synchronization**
If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your prescription drugs.

**How to access network pharmacies**
You can find a network pharmacy either online or by phone. See the Contact us section for how.

You may go to any of our network pharmacies. If you don’t get your prescriptions at a selected pharmacy, your prescriptions will not be a covered service under the plan. Pharmacies include network retail, mail order and specialty pharmacies.
Some prescription drugs are subject to quantity limits. This helps your provider and pharmacy ensure your prescription drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

Any prescription drug made to work beyond one month shall require the copayment amount that equals the expected duration of the medication.

The pharmacy may substitute a generic prescription drug for a brand-name prescription drug. Your cost share may be less if you use a generic drug when it is available.

Pharmacy types

Retail pharmacy
A retail pharmacy may be used for up to a 365 day supply of prescription drugs. A network retail pharmacy will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy
The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each prescription and refill is limited to a maximum 365 day supply.

Specialty pharmacy
We cover specialty prescription drugs when filled through a network retail or specialty pharmacy. Each prescription is limited to a maximum 30 day supply. You can view the list of specialty prescription drugs. See the Contact us section for how.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your provider, and/or your network pharmacy. The outcome of this review may include:
- Limiting coverage of a drug to one prescribing provider or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

What if the pharmacy you use 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 us to find another network pharmacy in your area.

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs
Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn’t approved by the FDA for this treatment.

Contraceptives (birth control)
For females who are able to become pregnant, covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from your provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a covered service. You can access a list of covered drugs and devices. See the Contact us section for how.
We also cover over-the-counter (OTC) and generic prescription drugs and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the brand-name prescription drug or device at no cost share.

**Preventive contraceptives important note:**
You may qualify for a medical exception if your provider determines that the contraceptives covered as preventive covered services under the plan are not medically appropriate for you. Your provider may request a medical exception and submit it to us for review.

**Diabetic supplies**
Covered services include but are not limited to the following:
- Alcohol swabs
- Blood glucose calibration liquid Diabetic syringes, needles and pens
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the Diabetic services, supplies, equipment, and self-care programs section for medical covered services.

**Immunizations**
Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

**Risk reducing breast cancer prescription drugs**
Covered services include prescription drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for medication side effects

The following are not covered services:
- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a covered service
- Dietary supplements including medical food
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That include the same active ingredient or a modified version of an active ingredient as a covered prescription drug unless we approve a medical exception
  - That is therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - That is therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception

That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)

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 unless listed as a covered service

That are used for the purpose of weight gain or loss 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; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body’s genes, genetic makeup or the expression of the body’s genes
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectable categories including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - 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 with the exception of Depo Provera and other injectable drugs for contraception
- Insulin pumps, tubing or other ancillary equipment and supplies for insulin pumps
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - 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 to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan’s drug guide
  - 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 is illegal, unethical, imprudent, abusive, not medically necessary or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addition, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer’s product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan’s drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan’s drug guide
Contraceptives (birth control)
For females who are able to become pregnant, covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from your provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a covered service. You can access a list of covered drugs and devices. See the Contact us section for how.

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

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

Risk reducing breast cancer prescription drugs
Covered services include prescription drugs used to treat people who are at an increased risk for breast cancer and a low risk for adverse medication side effects. You will need a prescription from your provider and have it filled at a network pharmacy.

Routine cancer screenings
Covered services include the following routine cancer screenings:
- Colonoscopies including pre-procedure specialist consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams
A routine preventive exam is a medical exam given 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
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:
- Annual routine office visit to a physician
• Hearing screening
• Vision screening
• Radiological services, lab and other tests
• For covered newborns, an initial hospital checkup

Well woman preventive visits
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 and also includes:
• Office visit to a physician, PCP, OB, GYN or OB/GYN for services including Pap smears
• Preventive care breast cancer (BRCA) gene blood testing
• Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
• Screening for urinary incontinence

Private duty nursing - outpatient
Covered services include private duty nursing care, ordered by a physician and provided by an R.N. or L.P.N. when:
• You are homebound
• Your physician orders services as part of a written treatment plan
• Services take the place of a hospital or skilled nursing facility stay
• Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
• Periodic skilled nursing visits are not adequate

The following are not covered services:
• Inpatient private duty nursing care
• Care provided outside the home
• Maintenance or custodial care
• Care for your convenience or the convenience of the family caregiver

Prosthetic device
A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

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

Coverage includes:
• Instruction and other services (such as attachment or insertion) so you can properly use the device
• 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

You may receive a prosthetic device as part of another covered service and therefore it will not be covered under this benefit.

The following are not covered services:
• Orthopedic shoes and therapeutic shoes, unless 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
Reconstructive breast surgery and supplies
Covered 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
  - Prostheses

Reconstructive surgery and supplies
Covered 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 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.

Covered services also include surgery, as soon as medically feasible, to fix teeth injured due to an accident when:

- Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the injury.
- The surgery returns the injured teeth to how they functioned before the accident.

Short-term cardiac and pulmonary rehabilitation services
Cardiac rehabilitation
Covered 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
Covered services include pulmonary rehabilitation services as part of your inpatient hospital stay if they are part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be covered 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. The services must follow a specific treatment plan, ordered by your physician. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- Hospital, skilled nursing facility, or hospice facility
- Home health care agency
- Physician

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your provider must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

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Cognitive rehabilitation, physical, occupational, and speech therapy
Covered 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, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or surgical procedure
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or surgical procedure
  - 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
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

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

The following are not covered services:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Skilled nursing facility
Covered services include precertified inpatient skilled nursing facility care. This includes:

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

Substance related disorders treatment
Covered services include the treatment of substance related 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 (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.

Treatment of substance related disorders in a general medical hospital is only covered if you are admitted to the hospital’s separate substance related disorders section or unit, unless you are admitted for the treatment of medical complications of substance related disorders.

As used here, “medical complications” include, but are not limited to:

- Electrolyte imbalances
- Malnutrition
- Cirrhosis of the liver
- Delirium tremens
- 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 psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group, and family therapies for the treatment of substance related disorders
  - Other outpatient substance related disorders treatment such as:
    o Partial hospitalization treatment provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    o Intensive outpatient program provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    o Ambulatory or outpatient detoxification which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    o 23 hour observation
    o Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Tests, images and labs – outpatient
Diagnostic complex imaging services
Covered services include:
• Computed tomography (CT) scans], including for preoperative testing
• 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 imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work
Covered services include:
• Lab
• Pathology
• Other tests

These are covered only when you get them from a licensed radiology provider or lab.

Diagnostic x-ray and other radiological services
Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology provider. See Diagnostic complex imaging services above for more information.

Therapies – Chemotherapy, infusion, radiation
Chemotherapy
Covered services for chemotherapy depend 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.

Infusion therapy
Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. **Covered services** include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a hospital
- A physician's office
- Your home from a home care provider

You can access the list of preferred infusion locations by contacting us.

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

Certain infused medications may be covered under the outpatient prescription drug benefit. You can access the list of specialty prescription drugs by contacting us.

**Radiation therapy**

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

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

**Transplant services**

**Covered services** include transplant services provided by a physician and hospital.

This includes the following transplant types:

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

**Covered services** also include:

- Travel and lodging expenses
  - If you are working with an Institutes of Excellence™ (IOE) facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the IOE facility
  - Coach class air fare, train or bus travel are examples of **covered services**

**Network of transplant facilities**

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your provider directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.
Important note:
If there are no IOE facilities assigned to perform your transplant type in your network, the National Medical Excellence® (NME) program will arrange for and coordinate your care at an IOE facility in another one of our provider networks. If you don’t get your transplant services at the IOE facility we designate, your cost share will be higher.

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 National Medical Excellence® (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.

The following are not covered 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

Urgent care services
Covered services include services and supplies to treat an urgent condition at an urgent care center as described below:
- **Urgent condition** within the network (in-network)
  - If you need care for an urgent condition, you should first seek care through your physician, PCP. If your physician is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- **Urgent condition** outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

The following are not covered services:
- Non-urgent care in an urgent care center

Vision care
Covered services include:
- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not covered services:
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Walk-in clinic
Covered services include, but are not unlimited to, health care services provided at a walk-in clinic for:
- Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- Preventive care immunizations administered within the scope of the clinic’s license
General plan exclusions

The following are not covered services under your plan:

Behavioral health treatment
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
- 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

Blood, blood plasma, synthetic blood, blood derivatives or
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 service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the Coverage and exclusions, Transplant services section

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, except where described in Coverage and exclusions under the Reconstructive breast surgery and supplies and Reconstructive surgery and supplies sections

Cost share waived
Any cost for a service when any out-of-network provider waives all or part of your copayment, coinsurance, deductible, or any other amount

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

Custodial care
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these 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 or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

**Durable medical equipment (DME)**

**Educational services**
Examples of these are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

**Examinations**
Any health or dental examinations needed:
- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel
- To go to a school, camp, 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 trials.

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

**Foot orthotic devices**
Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

**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

**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

**Medical supplies – outpatient disposable**

Any outpatient disposable supply or device. Examples of these include:
- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

**Mental health and substance use disorders conditions**

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care section*
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

**Missed appointments**

Any cost resulting from a canceled or missed appointment

**Nutritional support**

Any food item, including:
- Infant formulas
- Nutritional supplements
- Vitamins
- Prescription vitamins
- Medical foods
- Other nutritional items

**Other non-covered services**

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

**Other primary payer**

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer
Personal care, comfort or convenience items
Any service or supply primarily for your convenience and personal comfort or that of a third party

Prescription or non-prescription drugs and medicines - outpatient
- Outpatient prescription or non-prescription drugs and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

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 Covered services and exclusions section

Services outside of Guam, the USA Mainland and Hawaii
Services outside of Guam, the USA Mainland and Hawaii, that are not approved through the pre-authorization process

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

Sexual dysfunction and enhancement
Any treatment, prescription drug, 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 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 to enhance your strength, physical condition, endurance or physical performance

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

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound 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 *Covered services and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services and exclusions* 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 unless coverage is required by applicable laws

**Voluntary sterilization**

- Reversal of voluntary sterilization procedures, including related follow-up care

**Wilderness treatment programs**
See *Educational services* in this section

**Work related illness or injuries**
Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

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**Important note:**
A source of coverage or reimbursement is 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.
How your plan works

How your medical 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

Your cost share is lower when you use a network provider.

Providers
Our provider network is 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 in to the Aetna website.

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

How your medical plan works while you are covered out-of-network
With your out-of-network coverage:
• You can get care from providers who are not part of the Aetna network and from network providers without a PCP referral
• You may have to pay the full cost for your care, and then submit a claim to be reimbursed
• You are responsible to get any required precertification
• Your cost share will be higher

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 an Aetna member 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 this situation applies to you, contact us for details. If we approve your request to keep going to your current provider, we will tell you how long you can continue to see the provider. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

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

Who provides the care

Network providers
We have contracted with providers in the service area to provide covered services to you. These providers make up the network for your plan.

To get network benefits, you must use network providers. There are some exceptions:
• Emergency services – see the description of emergency services in the Coverage and exclusions section.
• Urgent care – see the description of urgent care in the Coverage and exclusions section.
• Transplants – see the description of transplant services in the Coverage and exclusions section.

You may select a network provider from the online directory through the Aetna website.

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

Your PCP
We encourage you to get covered services through a PCP. They will provide you with primary care.

How you choose your PCP
You can choose a PCP from the list of PCPs in our directory.

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

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

Changing your PCP
You may change your PCP at any time by contacting us.

Medical necessity, referral and precertification requirements

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

• The service is medically necessary
• For in-network benefits, you get the service from a network provider
• You or your provider precertifies the service when required

Medically necessary, medical necessity
The medical necessity requirements are in the Glossary section, where we define “medically necessary, medical necessity.” That is where we also explain what our medical directors or a physician they assign consider when determining if a service is medically necessary.

Important note:
We cover medically necessary, sex-specific covered services regardless of identified gender.

Precertification
You need pre-approval from us for some covered services. Pre-approval is also called precertification.

In-network
Your network physician is responsible for obtaining any necessary precertification before you get the care. Network providers cannot bill you if they fail to ask us for precertification. But if your physician requests precertification and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out-of-network
When you go to an out-of-network provider, you are responsible to get any required precertification from us. If you don’t precertify:

• Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your deductible or maximum out-of-pocket limit.]

Timeframes for precertification are listed below. For emergency services, precertification is not required, but you should notify us as shown.

To obtain precertification, contact us. You, your physician or the facility must call us within these timelines:

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency admission</td>
<td>Call at least 14 days before the date you are scheduled to be admitted</td>
</tr>
<tr>
<td>Emergency admission</td>
<td>Call within 48 hours or as soon as reasonably possible after you have been admitted</td>
</tr>
<tr>
<td>Urgent admission</td>
<td>Call before you are scheduled to be admitted</td>
</tr>
<tr>
<td>Outpatient non-emergency medical services</td>
<td>Call at least 14 days before the care is provided, or the treatment or procedure is scheduled</td>
</tr>
</tbody>
</table>

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your physician in writing of the precertification decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient stay in a facility, we will tell you, your physician and the facility about your precertified length of stay. If your physician recommends that you stay longer, the extra days will need to be precertified. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days.

If you or your provider request precertification and we don’t approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the Complaints, claim decisions and appeal procedures section.

Types of services that require precertification

Precertification is required for the following types of services and supplies:

<table>
<thead>
<tr>
<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stays in a hospital</td>
<td>Cosmetic and reconstructive surgery</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Emergency transportation by airplane</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
<td>Transcranial magnetic stimulation (TMS)</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for</td>
<td>Partial hospitalization treatment – mental disorder and substance related disorders treatment diagnoses</td>
</tr>
<tr>
<td>treatment of mental disorders and substance related disorders</td>
<td></td>
</tr>
<tr>
<td>Obesity surgery (bariatric)</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html

Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these prescription drugs:

For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary.

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.

Contact us or go online to get the most up-to-date precertification requirements and list of step therapy drugs.

Requesting a medical exception
Sometimes you or your provider may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your provider can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your provider 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
- F axing 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.

What the plan pays and what you pay
Who pays for your covered services – this plan, both of us, or just you? That depends.

The general rule
The schedule of benefits lists what you pay for each type of covered service. In general, this is how your benefit works:

- You pay the deductible, when it applies.
- Then the plan and you share the expense. Your share is called a copayment or .
- 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, and allowable amount for an out-of-network provider.
Negotiated charge

For health coverage:
This is the amount a network provider has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

Some providers are part of Aetna’s network for some Aetna plans but are not considered network providers for your plan. For those providers, the negotiated charge is the amount that provider has agreed to accept for rendering services or providing prescription drugs to members of your plan.

We may enter into arrangements with network providers or others related to:
- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:
- Value-based contracting
- Risk sharing
- Accountable care arrangements

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

For prescription drug services:
When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Allowable amount

This is the amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all charges above this amount. The allowable amount depends on the geographic area where you get the service or supply. Allowable amount doesn’t apply to involuntary services. These are services or supplies that are:
- Provided at a network facility by an out-of-network provider
- Not available from a network provider
- An emergency service

The table below shows the method for calculating the allowable amount for specific services or supplies:

<table>
<thead>
<tr>
<th>Service or supply:</th>
<th>Allowable amount is based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or supplies not mentioned below</td>
<td>105% of Medicare allowed rate</td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>140% of Medicare allowed rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>110% of average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td></td>
</tr>
</tbody>
</table>

Important note:
See Special terms used, below, for a description of what the allowable amount is based on.
If the provider bills less than the amount calculated using a method above, the allowable amount is what the provider bills.
Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a prescription drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider’s estimated costs for the service and leave the provider with a reasonable profit. This means for:
  - Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
  - Facilities that don’t report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the allowable amount. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.
- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific provider performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn’t have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable

We may make the following exceptions:
- For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
- Our rate may exclude other payments that CMS may make directly to hospitals or other providers and backdated adjustments
- For anesthesia, our rate may be at least 105% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes
- For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

When the allowable amount is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.

Our reimbursement policies
We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the allowable amount. When we do this, we consider:
- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the provider
We base our reimbursement policies on our review of:
- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren’t appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Use the ‘Estimate the Cost of Care’ tool or ‘Payment Estimator’ tool on the Aetna website. The website may contain additional information that can help you determine the cost of a service or supply.

Paying for covered services – the general requirements
There are several general requirements for the plan to pay any part of the expense for a covered service. For in-network coverage, they are:
- The service is medically necessary
- You get your care from a network provider
- You or your provider precertifies the service when required

For out-of-network coverage:
- The service is medically necessary
- You get your care from an out-of-network provider
- You or your provider precertifies the service when required

For outpatient prescription drugs, your costs are based on:
- The type of prescription you’re prescribed
- Where you fill the prescription

The plan may make some brand-name prescription drugs available to you at the generic prescription drug cost share.

Generally, your plan and you share the cost for covered services when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:
- You get services or supplies that are not medically necessary.
- Your plan requires precertification, your physician requests it, we deny it and you get the services without precertification.
- You get care from an out-of-network provider and the provider waives all or part of your cost share.

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 your maximum out-of-pocket limit.

Where your schedule of benefits fits in
The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive covered services and any benefit limitations that apply to your plan. It also shows any maximum out-of-pocket limits that apply.
Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like deductibles, copayments and coinsurance.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

**Coordination of benefits**

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “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 government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

**How COB works**

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

**Determining who pays**

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

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

<table>
<thead>
<tr>
<th>COB rule</th>
<th>Primary Plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-dependent or dependent</td>
<td>Plan covering you as an employee, retired employee or subscriber (not as a dependent)</td>
<td>Plan covering you as a dependent</td>
</tr>
<tr>
<td>COB rule</td>
<td>Primary Plan</td>
<td>Secondary plan</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Child – parents married or living together</td>
<td>Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)</td>
<td>Plan of parent whose birthday is later in the year</td>
</tr>
</tbody>
</table>
| Child – parents separated, divorced, or not living together | • Plan of parent responsible for health coverage in court order  
• Birthday rule applies if both parents are responsible or have joint custody in court order  
• Custodial parent’s plan if there is no court order | • Plan of other parent  
• Birthday rule applies (later in the year)  
• Non-custodial parent’s plan |
| Child – covered by individuals who are not parents (i.e. stepparent or grandparent) | Same rule as parent                                                      | Same rule as parent                                                          |
| Active or inactive employee                  | Plan covering you as an active employee (or dependent of an active employee) | Plan covering you as a laid off or retired employee (or dependent of a former employee) |
| Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation | Plan covering you as an employee or retiree (or dependent of an employee or retiree) | COBRA or state continuation coverage                                           |
| Longer or shorter length of coverage         | Plan that has covered you longer                                            | Plan that has covered you for a shorter period of time                         |
| Other rules do not apply                     | Plans share expenses equally                                                | Plans share expenses equally                                                  |

**How COB works with Medicare**

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it.

**Effect of prior plan coverage**

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current plan must be offered through the policyholder.

**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.

**Our rights**

We have the right to:
• Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
• Reimburse another health plan that paid a benefit we should have paid
• Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims
A claim is a request for payment that you or your health care provider submits to us when you want or get covered services. There are different types of claims. You or your provider may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within How your plan works. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes
Urgent care claim
An urgent claim is one for which the doctor treating you decides a 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. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 24 hours.

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. We will make a decision within 15 days.

Post-service claim
A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension
A concurrent care claim extension occurs when you need 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. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occur 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.

During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance 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.

Filing a claim
When you see a network provider, that office will usually send us a detailed bill for your services. If you see an out-of-network provider, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, providers and cost of your services.

The benefit payment determination is made based on many things, such as your deductible or coinsurance, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your provider for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the Complaints, claim decisions and appeal procedures section for that information.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint
You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you 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.

Appeal
When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures
Your provider may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in Benefit payments and claims in the How your plan works section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision.

Appeal of an adverse benefit determination
Urgent care or pre-service claim appeal
If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for
a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal
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 the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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 you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

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

- Contact the Guam Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Guam Department of Insurance
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the state. 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

Utilization review
Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your provider or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing provider or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

**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.
Eligibility, starting and stopping coverage

Eligibility
Who is eligible
The policyholder decides and tells us who is eligible for health care coverage.

When you can join the plan
You can enroll:
- Once each year during the annual enrollment period
- At other special times during the year (see the Special times you can join the plan section below)

You can enroll eligible family members (these are your “dependents”) at this time too.

Who can be a dependent on this plan
You can enroll the following family
- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Children you are responsible for under a qualified medical support order or court order

Adding new dependents
You can add new dependents during the year. These include any dependents described in the Who can be a dependent on this plan section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:
- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 after the event date.

Special times you and your dependents can join the plan
You can enroll in these situations:
- You didn’t enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

**Notification of change in status**
Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:
- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

**Starting Coverage**
Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

**Stopping Coverage**
Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn’t always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the Special coverage options after your coverage ends section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

**When will your coverage end**
Your coverage under this plan will end if:
- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer
- You have reached your overall maximum benefit under your plan

**When dependent coverage ends**
Dependent coverage will end if:
- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall maximum benefit.
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- Your dependent has exhausted the maximum benefit under your medical plan.
- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends.
  - You will need to complete a Declaration of Termination of Domestic Partnership.
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 coverage ends section for more information.

Why would we end your coverage?
We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

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

Special coverage options after your coverage ends
When coverage may continue under the plan
This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is the policyholder’s responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

How can you extend coverage if you are totally disabled when coverage ends?
Your coverage may be extended if you 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 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 plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their 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 when getting inpatient care when coverage ends?
Your coverage may be extended if you are getting inpatient care in a hospital or skilled nursing facility when coverage ends.

Benefits are extended for the condition that caused the hospital or skilled nursing facility stay or for complications from the condition. Benefits aren’t extended for other medical conditions.

You can continue to get care for this condition until the earliest of:
- When you are discharged
- When you no longer need inpatient care
- When you become covered by another health benefits plan
- 12 months of coverage

How can you extend coverage for hearing services and supplies when coverage ends?
If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:
- If the prescription for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

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 provisions**

**How you and we will interpret this certificate**
We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage.

**How we administer this plan**
We apply policies and procedures we’ve developed to administer this plan.

**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 policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only we 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 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 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 Complaints, claim decisions and appeal procedures section. You cannot take any action until 60 days after we receive written submission of a 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 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. Important things to keep are:

- Names of physicians 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 policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution 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
- 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 advance 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 ERO

Some other money issues

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. To the extent allowed by law, we will not accept an assignment to an out-of-network provider.

Financial sanctions exclusions
If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for covered 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.

Premium contribution
Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments
We sometimes pay too much for covered services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid, you or your provider, to return what we paid. If we don’t do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured
If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to that money, up to the amount we pay for your care. We have that right no matter whom the money comes from – for example, the other driver, the policyholder, or another insurance company.

To help us get paid back, you are doing these things now:
- Agreeing to repay us from money you receive because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you’ll tell us within 30 days of when you seek money for your injury or illness. You’ll hold any money you receive until we are paid in full. And you’ll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We don’t have to reduce the amount we’re due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.
Your health information
We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this plan, you agree to let your providers share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans
Glossary

Allowable amount
See *How your plan works – What the plan pays and what you pay.*

Behavioral health provider
A health professional who is properly licensed or certified to provide covered services for mental health and substance related disorders in the state where the person practices.

Brand-name prescription drug
An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance
A percentage paid by a covered person for a covered service.

Copay/copayments
A dollar amount or percentage paid by a covered person for a covered service.

Covered service
The benefits, subject to varying cost shares, covered in this plan. These are:
- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits
- Medically necessary. See the *How your plan works – Medical necessity, referral and precertification requirements* section and the Glossary for more information

Deductible
The amount a covered person pays for covered services per year before we start to pay.

Detoxification
The process of getting alcohol or other drugs out of an addicted person’s system and getting them physically stable.

Drug guide
A list of prescription drugs and devices established by us or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to [https://www.aetna.com/individuals-families/find-a-medication.html](https://www.aetna.com/individuals-families/find-a-medication.html).

Emergency medical condition
A severe medical condition that:
- Comes on suddenly
- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
- Loss of function to a body part or organ
- Danger to the health of an unborn baby

**Emergency services**
Treatment given in a hospital’s emergency room. This includes evaluation of and treatment to stabilize the emergency medical condition.

**Experimental or investigational**
Drugs, treatments or tests not yet accepted by physicians or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is experimental or investigational if:
- 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**
An FDA-approved drug with the same intended use as the brand-name product. It offers the same:
- Dosage
- Safety
- Strength
- Quality
- Performance

**Health professional**
A person who is authorized by law to provide health care services to the public; for example, physicians, nurses and physical therapists.

**Home health care agency**
An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

**Hospital**
An institution licensed as a hospital by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All hospitals must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.
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

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
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Lifetime maximum
The most this plan will pay for covered services incurred by a covered person during their lifetime.

Mail order pharmacy
A pharmacy where prescription drugs are legally dispensed by mail or another carrier.

Medically necessary/medical necessity
Health care services that we determine 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 we determine 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
- Following the standards set forth in our clinical policies and applying clinical judgment

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

Negotiated charge
See How your plan works – What the plan pays and what you pay.
Network provider
A provider listed in the directory for your plan. A NAP provider listed in the NAP directory is not a network provider. A network provider can also be referred to as an in-network provider.

Out-of-network provider
A provider who is not a network provider.

Physician
A health professional trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a physician can also be a primary care physician (PCP).

Precertification, precertify
Pre-approval that you or your provider receives from us before you receive certain covered services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Prescription drug
This is an instruction written by a physician that authorizes a patient to receive a service, supply, medicine or treatment.

Provider(s)
A physician, health professional, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don’t participate in Medicare.

Psychiatric hospital
An institution licensed or certified as a psychiatric hospital by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or mental disorders (including substance related disorders).

Residential treatment facility
An institution specifically licensed as a residential treatment facility by applicable laws to provide for mental health or substance related disorder residential treatment programs. It is credentialled by us 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/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)
For substance related 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
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

For detoxification programs within a residential setting:
- An R.N. must be onsite 24 hours/day for 7 days/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, we 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 laws to provide skilled nursing care.
Skilled nursing facilities also include:
- Rehabilitation hospitals
- Portions of a rehabilitation hospital
- A hospital designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance related disorders.

Skilled nursing services
Services provided by a registered nurse or licensed practical nurse 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 contact us to access the list of specialty drugs.
Specialty pharmacy
This is a pharmacy designated by us 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 are excluded from coverage, unless a first-line therapy drug is used first by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request or on our website at https://www.aetna.com/individuals-families/find-a-medication.html.

Substance related disorder
This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

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
- 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 that can be provided electronically by:
- Two-way audiovisual teleconferencing
- Telephone calls
- Any other method required by law

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent condition
An illness or injury that requires prompt medical attention but is not a life-threatening emergency medical condition.
Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a walk-in clinic:

- Ambulatory surgical center
- Emergency room
- Hospital
- Outpatient department of a hospital
- Physician’s office
- Urgent care facility
Additional Information Provided by

Government of Guam

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the
person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**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 95 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.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.
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.
Schedule of Benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

Prepared exclusively for:
Policyholder: Government of Guam
Policyholder number: 142939
Plan Name: SOB-1A/PPO 1500
Group policy effective date: October 1, 2019
Plan effective date: October 1, 2019
Plan issue date: October 1, 2019

Underwritten by Aetna Life Insurance Company in Guam

❤️aetna™
Schedule of benefits

This schedule of benefits (schedule) lists the deductibles, copayments or coinsurance, if any apply to the covered services you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The deductibles and copayments, if any, listed in the schedule below are the amounts that you pay for covered services.
  - For the covered services under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a copayment, you will be responsible for the percentage amount
- Coinsurance amounts, if any, listed in the schedule below are what the plan will pay for covered services.
- Sometimes your cost share shows a combination of your dollar amount copayment that you will be responsible for and the coinsurance percentage that your plan will pay.
- You are responsible to pay any deductibles, copayments and remaining coinsurance, if they apply and before the plan will pay for any covered services.
- This plan doesn’t cover every health care service. You pay the full amount of any health care service you get that is not a covered service.
- This plan has limits for some covered services. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-network and out-of-network providers
  - Separate limits for in-network and out-of-network providers
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan
See the schedule of benefits for more information about limits.
- Your cost share may vary if the covered service is preventive or not. Ask your physician or contact us if you have a question about what your cost share will be.

For examples of how cost share and deductible work, go to the Using your Aetna benefits section under Individuals & Families at https://www.aetnainternational.com/.

Important note:
Covered services are subject to the Plan Year deductible, maximum out-of-pocket, limits, copayment or coinsurance unless otherwise stated in this schedule of benefits.

All services outside of Guam, including the USA Mainland and Hawaii require pre-authorization. Services which are not approved through the pre-authorization process are not covered under your plan.

Under this plan, you will:
1. Pay your copayment
2. Then pay any remaining deductible
3. Then pay your coinsurance
Your copayment does not apply to any deductible.

How your deductible works
The deductible is the amount you pay for covered services each year before the plan starts to pay. This is in addition to any copayment or coinsurance you pay when you get covered services from an in-network, out-of-
network provider. This schedule of benefits shows the deductible amounts that apply to your plan. Once you have met your deductible, we will start sharing the cost when you get covered services. You will continue to pay copayments or coinsurance, if any, for covered services after you meet your deductible.

How your PCP or physician office visit cost share works
You will pay the PCP cost share when you get covered services from any PCP.

How your maximum out-of-pocket works
This 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 services for the remainder of that year.

Contact us
We are here to answer questions. See the Contact us section in your certificate.

Aetna Life Insurance Company’s group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features
Precertification covered services reduction
This only applies to out-of-network covered services:
Your certificate contains a complete description of the precertification process. You will find details in the Medical necessity, referral and precertification section.

If precertification for covered services isn’t completed, when required, it can result in any of the following benefit reductions:

• A $400 benefit reduction applied separately to each type of covered service
• The service is not covered

You may have to pay an additional portion of the allowable amount because you didn’t get precertification. This portion is not a covered service and doesn’t apply to your deductible or maximum out-of-pocket limit, if you have one.

Deductible
You have to meet your deductible before this plan pays for benefits.

<table>
<thead>
<tr>
<th>Deductible type</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,500 per year</td>
<td>$3,000 per year</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000 per year</td>
<td>$9,000 per year</td>
</tr>
</tbody>
</table>

Deductible waiver
There is no in-network deductible for the following covered services:

• Preventive care

Maximum out-of-pocket limit
<table>
<thead>
<tr>
<th>Maximum out-of-pocket type</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000 per year</td>
<td>$0 per year</td>
</tr>
<tr>
<td>Family</td>
<td>$9,000 per year</td>
<td>$0 per year</td>
</tr>
</tbody>
</table>

**General coverage provisions**
This section explains the deductible, maximum out-of-pocket limit and limitations listed in this schedule.

**Deductible provisions**
Covered services that are subject to the deductible include those provided under the medical plan and the prescription drug plan.

The deductible may not apply to some covered services. You still pay the copayment or coinsurance, if any, for these covered services.

**Copayment**
This is a dollar amount or percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

**Coinsurance**
This is a percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

**Maximum out-of-pocket limit**
The maximum out-of-pocket limit is the most you will pay per year in copayments, coinsurance and deductible, if any, for covered services. Covered services that are subject to the maximum out-of-pocket limit include those provided under the medical plan and the outpatient prescription drug plan.

Covered services apply to the in-network and out-of-network maximum out-of-pocket limit. In-network covered services will apply only to the in-network maximum out-of-pocket limit. Out-of-network covered services will apply only to the out-of-network maximum out-of-pocket limit.

Certain costs that you have do not apply toward the maximum out-of-pocket limit. These include:

- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the allowable amount

**Limit provisions**
Covered services applied to the in-network limit will not apply to the out-of-network limit. Covered services applied to the out-of-network limit will not apply to the in-network limit.
Your financial responsibility and decisions regarding benefits
We base your financial responsibility for the cost of covered services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.
## Covered services

### Acupuncture

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

Visit limit per year: 30

### Ambulance services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>80% per trip after deductible</td>
<td>Paid same as in-network</td>
</tr>
<tr>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>Non-emergency services</td>
<td>80% per trip after deductible</td>
<td>80% per trip after deductible</td>
</tr>
</tbody>
</table>

### Applied behavior analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied behavior analysis</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
### Autism spectrum disorder

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and testing</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Treatment</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Clinical trials

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental or investigational therapies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Routine patient costs</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Diabetic services, supplies, equipment, and self-care programs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic services</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Diabetic equipment</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Diabetic self-care programs</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
### Durable medical equipment (DME)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME</td>
<td>80% per item after deductible</td>
<td>70% per item after deductible</td>
</tr>
<tr>
<td>Limit per year</td>
<td>unlimited</td>
<td>unlimited</td>
</tr>
</tbody>
</table>

### Emergency services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room</td>
<td>80% (per visit after deductible)</td>
<td>Paid same as in-network</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>50% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

**Emergency services important note:**

*Out-of-network providers* do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.

### Habilitation therapy services

**Physical, occupational and speech therapies**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT, OT, ST therapies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Hearing aids

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids</td>
<td>80% per item after deductible</td>
<td>70% per item after deductible</td>
</tr>
<tr>
<td>Limit</td>
<td>One per ear every plan year</td>
<td>One per ear every plan year</td>
</tr>
<tr>
<td>Limit</td>
<td>$500</td>
<td>$500</td>
</tr>
</tbody>
</table>

AI GU PPOSOB 142939 8
### Hearing exams

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing exams</td>
<td>Covered based on type of service and where it is received</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limit</td>
<td>One every 24 months</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Home health care

A visit is a period of 4 hours or less

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

Visit limit per year

<table>
<thead>
<tr>
<th></th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>120</td>
<td>120</td>
<td></td>
</tr>
</tbody>
</table>

**Home health care important note:**

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

### Hospice care

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - room and board</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
<tr>
<td>Day limit per lifetime</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>
### Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

### Hospital care

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
</tbody>
</table>

### Infertility services

#### Basic infertility

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of basic infertility</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Maternity and related newborn care

Includes complications

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
<tr>
<td>Services performed in physician or specialist office or a facility</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Other services and supplies</td>
<td>80% after deductible</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

### Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the Maternity section of the certificate. It will give you more information about coverage for maternity care under this plan.
Mental health treatment
Coverage provided is the same as for any other illness

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services-room and board including residential treatment facility</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider Includes telemedicine consultation</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Outpatient mental health telemedicine cognitive therapy consultations by a physician or behavioral health provider</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Other outpatient services including:</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>• Behavioral health services in the home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial hospitalization treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive outpatient program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The cost share doesn’t apply to in-network peer counseling support services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Obesity surgery

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

Limit per lifetime | $10,000 | $10,000

## Oral and maxillofacial treatment (mouth, jaws and teeth)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of mouth, jaws and teeth</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

## Outpatient prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs</td>
<td>70% per supply after deductible</td>
</tr>
</tbody>
</table>

## Outpatient prescription drugs

**Preferred generic prescription drugs**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$15 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$15 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Preferred brand-name prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$30, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$30, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Non-preferred generic prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$100, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$100, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Non-preferred brand-name prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$100, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$100, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Specialty prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a specialty pharmacy or retail pharmacy</td>
<td>$100, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Anti-cancer drugs taken by mouth

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail or mail order pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Insulin

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail or mail order pharmacy</td>
<td>$0, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Outpatient surgery

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>At hospital outpatient department</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Physician office hours (not-surgical, not preventive)</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Physician surgical services</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist office hours (not-surgical, not preventive)</td>
<td>$40 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Specialist surgical services</td>
<td>$40 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>All other services</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunizations limit</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your <strong>physician</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine physical exam</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine physical exam limits</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well woman GYN exam</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
<tr>
<td>Well woman GYN exam limit</td>
<td>Subject to any age and visit limits provided for in the comprehensive</td>
<td>Subject to any age and visit limits provided for in the comprehensive</td>
</tr>
</tbody>
</table>
### Prosthetic devices

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic devices</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Reconstructive surgery and supplies
Including breast surgery

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery and supplies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Routine cancer screenings

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>100% per test, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Digital rectal examination (DRE)</td>
<td>100% per exam, no deductible applies</td>
<td>70% per exam after deductible</td>
</tr>
<tr>
<td>Double contrast barium enema (DCBE)</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Fecal occult blood test (FOBT)</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Mammogram</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) test</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Cancer screening limits</td>
<td>Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items</td>
<td>Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items</td>
</tr>
</tbody>
</table>
Short-term rehabilitation services
Cardiac rehabilitation

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

Pulmonary rehabilitation

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

Cognitive rehabilitation

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
### Physical, Occupational and Speech Therapies

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT, OT and ST</td>
<td>$40 then the plan pays 100% per visit no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit limit per year</td>
<td>60</td>
<td>60</td>
</tr>
</tbody>
</table>

### Spinal Manipulation

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Manipulation</td>
<td>$40 then the plan pays 100% per visit, no deductible applies</td>
<td>75% per visit after deductible</td>
</tr>
</tbody>
</table>

### Skilled nursing facility

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - room and board</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
</tbody>
</table>

| Day limit per year | 60 | 60 |

### Substance related disorders treatment
Includes detoxification, rehabilitation and residential treatment facility
Coverage provided is the same as for any other illness

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services-room and board during a hospital stay</td>
<td>80% per admission after deductible</td>
<td>70% per admission after deductible</td>
</tr>
<tr>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider Includes telemedicine consultation</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program</td>
<td>80% per visit after deductible</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>The cost share doesn’t apply to in-network peer counseling support services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tests, images and labs – outpatient Diagnostic complex imaging services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Diagnostic lab work</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Description</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic x-ray and other radiological services</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapies</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infusion therapy</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation therapy</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory therapy</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (IOE facility) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-IOE Facility) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services and supplies</td>
<td>80% per transplant after deductible</td>
<td>70% per transplant after deductible</td>
</tr>
<tr>
<td>Physician services</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care facility</td>
<td>$50 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Non-urgent use of an urgent care facility or provider</td>
<td>50% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

**Vision care**  
Performed by an ophthalmologist or optometrist and includes refraction

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 visit every 12 months</td>
<td>Not covered</td>
</tr>
<tr>
<td>Walk-in clinic</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Non-emergency services</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Preventive immunizations</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Immunization limits</td>
<td>Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
<td>Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician</td>
<td>For details, contact your physician</td>
</tr>
</tbody>
</table>
Preferred provider organization (PPO) medical plan

Certificate of coverage
Prepared exclusively for:
Policyholder: Government of Guam
Policyholder number: 142939
Plan name: Certificate-3/HSA 2000
Group policy effective date: October 1, 2019
Plan effective date: October 1, 2019
Plan issue date: October 1, 2019

Underwritten by Aetna Life Insurance Company

[Logo]
TABLE OF CONTENTS

Welcome .......................................................................................................................... 3
Coverage and exclusions .............................................................................................. 5
General plan exclusions .............................................................................................. 25
How your plan works .................................................................................................... 30
Complaints, claim decisions and appeal procedures .................................................. 40
Eligibility, starting and stopping coverage .................................................................... 43
General provisions – other things you should know .................................................... 46
Glossary .......................................................................................................................... 50

Schedule of benefits Issued with your certificate of coverage
Welcome

At Aetna, your health goals lead the way, so we’re joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it’s our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction
This is your certificate of coverage or “certificate.” It describes your covered services – what they are and how to get them. The schedule of benefits tells you how we share expenses for covered services and explains any limits. Along with the group policy, they describe your Aetna plan. Each may have amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It’s really important that you read the entire certificate and your schedule of benefits. You can return them to us, within 30 days, if you are not happy with the coverage. When you do, we will cancel coverage as of your start date. We’ll also refund any premium contribution minus any benefits that have been paid. This doesn’t apply to transferred business. See the Effect of prior coverage.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the General coverage provisions section of the schedule of benefits.

If you need help or information, see the Contact us section below.

How we use words
When we use:
- “You” and “your” we mean you and any covered dependents (if your plan allows dependent coverage)
- “Us,” “we,” and “our” we mean Aetna
- Words that are in bold, we define them in the Glossary section

Contact us
For questions about your plan, you can contact us by:
- Calling the toll-free number on your ID card
- Logging in to the Aetna website at https://www.aetnainternational.com/
- Writing us at 151 Farmington Ave, Hartford, CT 06156

Your member website is available 24/7. With your member website, you can:
- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a provider, research providers, care and treatment options
- View and manage claims
- Find information on health and wellness

Your ID card
Show your ID card each time you get covered services from a provider. Only members on your plan can use your ID card. We will mail you your ID card. If you haven’t received it before you need covered services, or if you lose it, you can print a temporary one using the Aetna website.
Wellness and other rewards
You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your provider about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to copayment, deductible or coinsurance amounts
- Contributions to your health savings account
- Merchandise
- Coupons
- Gift or debit cards
- Any combination of the above

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 and 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 their services and discounted goods.
Coverage and exclusions

Your plan provides covered services. These are:
- Described in this section.
- Not listed as an exclusion in this section or the General plan exclusions section.
- Not beyond any limits in the schedule of benefits.
- Medically necessary. See the How your plan works – Medical necessity and precertification requirements section and the Glossary for more information.

For covered services under the outpatient prescription drug plan:
- You need a prescription from the prescribing provider
- You need to show your ID card to the network pharmacy when you get a prescription filled

This plan provides insurance coverage for many kinds of covered services, such as a doctor’s care and hospital stays, but some services aren’t covered at all or are limited. For other services, the plan pays more of the expense.

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 service only up to a set number of visits a year. This is a limitation.
- Your provider may recommend services that are considered experimental or investigational services. But an experimental or investigational service is not covered and is an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a terminal illness. See Clinical trials in the list of services below.

Some services require precertification from us. For more information see the How your plan works – Medical necessity and precertification requirements section.

The covered services and exclusions below appear alphabetically to make it easier to find what you’re looking for. You can find out about limitations for covered services in the schedule of benefits. If you have questions, contact us.

Acupuncture
Covered services include acupuncture services provided by a physician if the service is provided as a form of anesthesia in connection with a covered surgical procedure.

The following are not covered services:
- Acupuncture, other than for anesthesia
- Acupressure

Ambulance services
An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency
Covered services include emergency transport to a hospital by a licensed ambulance:
- To the first hospital to provide emergency services
- From one hospital to another if the first hospital can’t provide the emergency services you need
- When your condition is unstable and requires medical supervision and rapid transport
**Non-emergency**

**Covered services** also include precertified transportation to a hospital by a licensed ambulance:
- 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; limited to 100 miles
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not covered services:
- Non-emergency airplane transportation by an out-of-network provider
- Ambulance services for routine transportation to receive outpatient or inpatient services

**Applied behavior analysis**

**Covered services** include certain 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
- Are responsible for observable improvements in behavior

**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.

**Covered services** include services and supplies provided by a physician or behavioral health provider for:
- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

**Clinical trials**

**Routine patient costs**

**Covered services** include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered services:
- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

**Experimental or investigational therapies**

**Covered services** include drugs, devices, treatments, or procedures from a provider under an “approved clinical trial” only when you have cancer or a terminal illness. All of the following conditions must be met:
- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:
- The Food and Drug Administration (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, when this is required
• The clinical trial has been approved by an institutional review board that will oversee it
• The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  – It conforms to standards of the NCI or other applicable federal organization
  – It takes place at an NCI-designated cancer center or at more than one institution
• You are treated in accordance with the procedures of that study

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• You are treated in accordance with the procedures of that study

Diabetic services, supplies, equipment, and self-care programs
Covered services include:
• Services
  – Foot care to minimize the risk of infection
• Supplies
  – Injection devices including syringes, needles and pens
  – Test strips - blood glucose, ketone and urine
  – Blood glucose calibration liquid
  – Lancet devices and kits
  – Alcohol swabs
• Equipment
  – External insulin pumps and pump supplies
  – Blood glucose monitors without special features, unless required due to blindness
• Prescribed self-care programs with a health care provider certified in diabetes self-care training

Durable medical equipment (DME)
DME and the accessories needed to operate it are:
• Made to withstand prolonged use
• Mainly used in the treatment of 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

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.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:
• One item of DME for the same or similar purpose
• Repairing DME due to normal wear and tear
• A new DME item you need because your physical condition has changed
• Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not covered services:
• Communication aid
• Elevator
• Maintenance and repairs that result from misuse or abuse
• Massage table
• Message device (personal voice recorder)
• Over bed table
• Portable whirlpool pump
• Sauna bath
• Telephone alert system
• Vision aid
• Whirlpool

Emergency services
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 help.

Covered services include only outpatient services to evaluate and stabilize an emergency medical condition in a hospital emergency room. You can get emergency services from network providers or out-of-network providers.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the How your plan works – Medical necessity and precertification requirements section and the Coverage and exclusions section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your network physician or primary care physician (PCP).

Non-emergency services
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 for this information.
Habilitation therapy services
Habilitation therapy services 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). The services must follow a specific treatment plan, ordered by your physician. The services must be performed by:
- Licensed or certified physical, occupational or speech therapist
- Hospital, skilled nursing facility or hospice facility
- Home health care agency
- Physician

Outpatient physical, occupational, and speech therapy
Covered services include:
- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences)

The following are not covered services:
- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids
Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:
- Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:
- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams
Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing specialist.
The following are not covered services:
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay

Home health care
Covered 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 a stay in a hospital or a skilled nursing facility, or you are unable 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
- 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

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.

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

The following are not covered services:
- Custodial care
- 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
Covered 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
- Psychological and dietary counseling
- Pain management and symptom control

Hospice care services provided by the providers below will 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

The following are not covered services:
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

**Hospital care**

**Covered services** include inpatient and outpatient hospital care. This includes:
- Semi-private room and board. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a hospital, including the facility charge.
- Services of physicians employed by the hospital.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.

The following are not covered services:
- All services and supplies provided in:
  - Rest homes
  - Any place considered a person’s main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

**Infertility services**

**Basic infertility**

**Covered services** include seeing a 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.

The following are not covered services:
- All infertility services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Artificial insemination services.

**Maternity and related newborn care**

**Covered services** include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, covered services include:
- No less than 48 hours of inpatient care in a hospital after a vaginal delivery
- No less than 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

Covered services also include services and supplies needed for circumcision by a provider.

The following are not covered services:
• 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
Covered services include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider including:
• Inpatient room and board at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), 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 disorders
  – Other outpatient mental health treatment such as:
    0 Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
    0 Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
    0 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
    0 Electro-convulsive therapy (ECT)
    0 Transcranial magnetic stimulation (TMS)
    0 Psychological testing
    0 Neuropsychological testing
    0 23 hour observation
    0 Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Obesity surgery and services
Obesity surgery is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your physician will determine whether you qualify for obesity surgery.

Covered services include:
• An initial medical history and physical exam
• Diagnostic tests given or ordered during the first exam
• Outpatient prescription drugs included under the Outpatient prescription drugs section
• One obesity surgical procedure
• A multi-stage procedure when planned and approved by us
• Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not covered services:
• Weight management treatment
• Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
• Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - 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 surgery (treatment of mouth, jaws and teeth)
Covered services include the following when provided by a physician, a dentist and hospital:
• Surgery needed to:
  - Cut out 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.
• Related dental services are limited to:
  - The first placement of a permanent crown or cap to repair a broken tooth
  - The first placement of dentures or bridgework to replace lost teeth
  - Orthodontic therapy to pre-position teeth

The following are not covered services:
• Services normally covered under a dental plan
• Dental implants

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

<table>
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<tr>
<th>Important note:</th>
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<tr>
<td>Some surgeries can be done safely in a physician's office. For those surgeries, your plan will pay only for physician, PCP services and not for a separate fee for facilities.</td>
</tr>
</tbody>
</table>

The following are not covered services:
• A stay in a hospital (see Hospital care in this section)
• A separate facility charge for surgery performed in a physician's office
• Services of another physician for the administration of a local anesthetic

Physician services
Covered services include services by your physician to treat an illness or injury. You can get services:
• At the physician's office

AI GU HSACOC 142939
- In your home
- In a hospital
- From any other inpatient or outpatient facility
- By way of telemedicine

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

**Telemedicine** may have a different cost share from other **physician services**. See your schedule of benefits.

Other services and supplies that your **physician** may provide:
- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

**Prescription drugs - outpatient**
Read this section carefully. This plan does not cover all **prescription drugs** and some coverage may be limited. This doesn’t mean you can’t get **prescription drugs** that aren’t covered; you can, but you have to pay for them yourself. For more information about **prescription drug benefits**, including limits, see the schedule of benefits.

**Important note:**
A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

**Covered services** are based on the drugs in the **drug guide**. Your cost may be higher if you’re prescribed a **prescription drug** that is not listed in the **drug guide**. You can find out if a **prescription drug** is covered; see the **Contact us** section.

Your **provider** can give you a **prescription** in different ways including:
- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

**Prescription drug synchronization**
If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy can coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

**How to access network pharmacies**
You can find a network pharmacy either online or by phone. See the **Contact us** section for how.

You may go to any of our network pharmacies. If you don’t get your **prescriptions** at a selected pharmacy, your prescriptions will not be a **covered service** under the plan. Pharmacies include network retail, mail order and specialty pharmacies.
Some prescription drugs are subject to quantity limits. This helps your provider and pharmacy ensure your prescription drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

Any prescription drug made to work beyond one month shall require the copayment amount that equals the expected duration of the medication.

The pharmacy may substitute a generic prescription drug for a brand-name prescription drug. Your cost share may be less if you use a generic drug when it is available.

**Pharmacy types**

**Retail pharmacy**
A retail pharmacy may be used for up to a 365 day supply of prescription drugs. A network retail pharmacy will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

**Mail order pharmacy**
The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each prescription and refill is limited to a maximum 365 day supply.

**Specialty pharmacy**
We cover specialty prescription drugs when filled through a network retail or specialty pharmacy. Each prescription is limited to a maximum 30 day supply. You can view the list of specialty prescription drugs. See the Contact us section for how.

**Prescription drugs** covered by this plan are subject to misuse, waste, or abuse utilization review by us, your provider, and/or your network pharmacy. The outcome of this review may include:
- Limiting coverage of a drug to one prescribing provider or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

**What if the pharmacy you use 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 us to find another network pharmacy in your area.

**Other covered services**

**Anti-cancer drugs taken by mouth, including chemotherapy drugs**
Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn’t approved by the FDA for this treatment.

**Contraceptives (birth control)**
For females who are able to become pregnant, covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from your provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a covered service. You can access a list of covered drugs and devices. See the Contact us section for how.
We also cover over-the-counter (OTC) and generic prescription drugs and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the brand-name prescription drug or device at no cost share.

Preventive contraceptives important note:
You may qualify for a medical exception if your provider determines that the contraceptives covered as preventive covered services under the plan are not medically appropriate for you. Your provider may request a medical exception and submit it to us for review.

Diabetic supplies
Covered services include but are not limited to the following:
- Alcohol swabs
- Blood glucose calibration liquid Diabetic syringes, needles and pens
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the Diabetic services, supplies, equipment, and self-care programs section for medical covered services.

Immunizations
Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Risk reducing breast cancer prescription drugs
Covered services include prescription drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for medication side effects

The following are not covered services:
- Abortion drugs
- Allergy sera and extracts given by Injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a covered service
- Dietary supplements including medical food
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That include the same active ingredient or a modified version of an active ingredient as a covered prescription drug unless we approve a medical exception
  - That is therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - That is therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception.

That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF).

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 unless listed as a covered service.

That are used for the purpose of weight gain or loss 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; for example, two antihistamines for the same condition.
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body’s genes, genetic makeup or the expression of the body’s genes.
- Immunizations related to travel or work.
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate.
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate.
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility.
- Injectable drugs including:
  - Any charges for the administration or injection of prescription drugs.
  - Needles and syringes except for those used for insulin administration.
  - 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 with the exception of Depo Provera and other injectable drugs for contraception.
- Insulin pumps, tubing or other ancillary equipment and supplies for insulin pumps.
- Off-label drug use except for indications recognized through peer-reviewed medical literature.
- Prescription drugs:
  - 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 to a dental condition.
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan’s drug guide.
  - 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 is illegal, unethical, imprudent, abusive, not medically necessary or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card.
- Replacement of lost or stolen prescriptions.
- Test agents except diabetic test agents.
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addiction, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF.
- We reserve the right to exclude:
  - A manufacturer’s product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan’s drug guide.
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan’s drug guide.
Contraceptives (birth control)
For females who are able to become pregnant, covered services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a prescription from your provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a covered service. You can access a list of covered drugs and devices. See the Contact us section for how.

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

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

Risk reducing breast cancer prescription drugs
Covered services include prescription drugs used to treat people who are at an increased risk for breast cancer and a low risk for adverse medication side effects. You will need a prescription from your provider and have it filled at a network pharmacy.

Routine cancer screenings
Covered services include the following routine cancer screenings:
- Colonoscopies including pre-procedure specialist consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams
A routine preventive exam is a medical exam given 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
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:
- Annual routine office visit to a physician
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial hospital checkup

**Well woman preventive visits**
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 and also includes:
- Office visit to a physician, PCP, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

**Private duty nursing - outpatient**
**Covered services** include private duty nursing care, ordered by a physician and provided by an R.N. or L.P.N.
when:
- You are homebound
- Your physician orders services as part of a written treatment plan
- Services take the place of a hospital or skilled nursing facility stay
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:
- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

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

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

Coverage includes:
- Instruction and other services (such as attachment or insertion) so you can properly use the device
- 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

You may receive a prosthetic device as part of another covered service and therefore it will not be covered under this benefit.

The following are not **covered services**:
- Orthopedic shoes and therapeutic shoes, unless 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
Reconstructive breast surgery and supplies
Covered 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
  - Prostheses

Reconstructive surgery and supplies
Covered 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 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.

Covered services also include surgery, as soon as medically feasible, to fix teeth injured due to an accident when:

- Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the injury.
- The surgery returns the injured teeth to how they functioned before the accident.

Short-term cardiac and pulmonary rehabilitation services
Cardiac rehabilitation
Covered 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
Covered services include pulmonary rehabilitation services as part of your inpatient hospital stay if they are part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be covered 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. The services must follow a specific treatment plan, ordered by your physician. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- Hospital, skilled nursing facility, or hospice facility
- Home health care agency
- Physician

Covered services include:

- Spinal manipulation to correct a musculoskeletal problem. Your provider must establish or approve a treatment plan that details the treatment and specifies frequency and duration.
Cognitive rehabilitation, physical, occupational, and speech therapy

Covered 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, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or surgical procedure
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or surgical procedure
  - 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
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

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

The following are not covered services:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Skilled nursing facility

Covered services include precertified inpatient skilled nursing facility care. This includes:

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

Substance related disorders treatment

Covered services include the treatment of substance related 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 (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.

Treatment of substance related disorders in a general medical hospital is only covered if you are admitted to the hospital’s separate substance related disorders section or unit, unless you are admitted for the treatment of medical complications of substance related disorders.

As used here, “medical complications” include, but are not limited to:

- Electrolyte imbalances
- Malnutrition
- Cirrhosis of the liver
- Delirium tremens
- 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 psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  – Individual, group, and family therapies for the treatment of substance related disorders
  – Other outpatient substance related disorders treatment such as:
    o Partial hospitalization treatment provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    o Intensive outpatient program provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    o Ambulatory or outpatient detoxification which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    o 23 hour observation
    o Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Tests, images and labs – outpatient
Diagnostic complex imaging services
Covered services include:
• Computed tomography (CT) scans, including for preoperative testing
• 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 imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work
Covered services include:
• Lab
• Pathology
• Other tests

These are covered only when you get them from a licensed radiology provider or lab.

Diagnostic x-ray and other radiological services
Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology provider. See Diagnostic complex imaging services above for more information.

Therapies – Chemotherapy, infusion, radiation
Chemotherapy
Covered services for chemotherapy depend 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.

Infusion therapy
Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. Covered services include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a hospital
- A physician's office
- Your home from a home care provider

You can access the list of preferred infusion locations by contacting us.

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

Certain infused medications may be covered under the outpatient prescription drug benefit. You can access the list of specialty prescription drugs by contacting us.

Radiation therapy
Covered services include the following radiology services provided by a health professional:

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

Transplant services
Covered services include transplant services provided by a physician and hospital.

This includes the following transplant types:

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

Covered services also include:

- Travel and lodging expenses
  - If you are working with an Institutes of Excellence™ (IOE) facility that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, to travel between home and the IOE facility
  - Coach class air fare, train or bus travel are examples of covered services

Network of transplant facilities
We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your provider directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.
Important note:
If there are no IOE facilities assigned to perform your transplant type in your network, the National Medical Excellence® (NME) program will arrange for and coordinate your care at an IOE facility in another one of our provider networks. If you don’t get your transplant services at the IOE facility we designate, your cost share will be higher.

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 National Medical Excellence® (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.

The following are not covered 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

Urgent care services
Covered services include services and supplies to treat an urgent condition at an urgent care center as described below:
- Urgent condition within the network (in-network)
  - If you need care for an urgent condition, you should first seek care through your physician, PCP. If your physician is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- Urgent condition outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

The following are not covered services:
- Non-urgent care in an urgent care center

Vision care
Covered services include:
- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not covered services:
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Walk-in clinic
Covered services include, but are not unlimited to, health care services provided at a walk-in clinic for:
- Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- Preventive care immunizations administered within the scope of the clinic’s license
General plan exclusions

The following are not covered services under your plan:

Behavioral health treatment
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
  • 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

Blood, blood plasma, synthetic blood, blood derivatives or
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 service of blood donors, including yourself, apheresis or plasmapheresis
  • The blood you donate for your own use, excluding administration and processing expenses and except where described in the Coverage and exclusions, Transplant services section

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, except where described in Coverage and exclusions under the Reconstructive breast surgery and supplies and Reconstructive surgery and supplies sections

Cost share waived
Any cost for a service when any out-of-network provider waives all or part of your copayment, coinsurance, deductible, or any other amount

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

Custodial care
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:
  • Routine patient care such as changing dressings, periodic turning and positioning in bed
  • Administering oral medications
  • Care of 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 or changing containers and clamping tubing
  • Watching or protecting you
  • Respite care, adult or child day care, or convalescent care
  • Institutional care, including room and board for rest cures, adult day care and convalescent care
• Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
• Any other services that a person without medical or paramedical training could be trained to perform

Durable medical equipment (DME)

Educational services
Examples of these are:
• Any service or supply for education, training or retraining services or testing. This includes:
  – Special education
  – Remedial education
  – Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  – Job training
  – Job hardening programs
• Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations
Any health or dental examinations needed:
• Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
• To buy insurance or to get or keep a license.
• To travel
• To go to a school, camp, 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 trials.

Foot care
Routine services and supplies for the following:
• Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
• Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
• Treatment of calluses, bunions, toenails, hammertoes or fallen arches
• Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

Foot orthotic devices
Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

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

Maintenance care
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Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services

**Medical supplies – outpatient disposable**
Any outpatient disposable supply or device. Examples of these include:
- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

**Mental health and substance use disorders conditions**
The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the Coverage and exclusions-Preventive care section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

**Missed appointments**
Any cost resulting from a canceled or missed appointment

**Nutritional support**
Any food item, including:
- Infant formulas
- Nutritional supplements
- Vitamins
- Prescription vitamins
- Medical foods
- Other nutritional items

**Other non-covered services**
- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

**Other primary payer**
Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer
Personal care, comfort or convenience items
Any service or supply primarily for your convenience and personal comfort or that of a third party

Prescription or non-prescription drugs and medicines - outpatient
- Outpatient prescription or non-prescription drugs and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

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 Covered services and exclusions section

Services outside of Guam, the USA Mainland and Hawaii
Services outside of Guam, the USA Mainland and Hawaii, that are not approved through the pre-authorization process

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

Sexual dysfunction and enhancement
Any treatment, prescription drug, 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 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 to enhance your strength, physical condition, endurance or physical performance

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

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
• Sensory or hearing and sound 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 *Covered services and exclusions* section
  • Hypnosis and other therapies
  • Medications, except as specifically provided in the *Covered services and exclusions* 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 unless coverage is required by applicable laws

**Voluntary sterilization**
  • Reversal of voluntary sterilization procedures, including related follow-up care

**Wilderness treatment programs**
*See Educational services in this section*

**Work related illness or injuries**
Coverage available to you under workers’ compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

**Important note:**
A source of coverage or reimbursement is 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.
How your plan works

How your medical 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

Your cost share is lower when you use a network provider.

Providers
Our provider network is 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 in to the Aetna website.

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

How your medical plan works while you are covered out-of-network
With your out-of-network coverage:
  • You can get care from providers who are not part of the Aetna network and from network providers without a PCP referral
  • You may have to pay the full cost for your care, and then submit a claim to be reimbursed
  • You are responsible to get any required precertification
  • Your cost share will be higher

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 an Aetna member 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 this situation applies to you, contact us for details. If we approve your request to keep going to your current provider, we will tell you how long you can continue to see the provider. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

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

Who provides the care

Network providers
We have contracted with providers in the service area to provide covered services to you. These providers make up the network for your plan.

To get network benefits, you must use network providers. There are some exceptions:
  • Emergency services – see the description of emergency services in the Coverage and exclusions section.
  • Urgent care – see the description of urgent care in the Coverage and exclusions section.
- Transplants – see the description of transplant services in the **Coverage and exclusions** section.

You may select a **network provider** from the online directory through the Aetna website.

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

**Your PCP**
We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

**How you choose your PCP**
You can choose a **PCP** from the list of **PCPs** in our directory.

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

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

**Changing your PCP**
You may change your **PCP** at any time by contacting us.

**Medical necessity, referral and precertification requirements**

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

- The service is **medically necessary**
- For **in-network benefits**, you get the service from a **network provider**
- You or your **provider** precertifies the service when required

**Medically necessary, medical necessity**
The **medical necessity** requirements are in the **Glossary** section, where we define “**medically necessary, medical necessity**.” That is where we also explain what our medical directors or a physician they assign consider when determining if a service is **medically necessary**.

### Important note:
We cover medically necessary, sex-specific covered services regardless of identified gender.

**Precertification**
You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

**In-network**
Your network **physician** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your physician requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

**Out-of-network**
When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don’t **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
• You will be responsible for the unpaid bills.
• Your additional out-of-pocket expenses will not count toward your deductible or maximum out-of-pocket limit.]

Timeframes for precertification are listed below. For emergency services, precertification is not required, but you should notify us as shown.

To obtain precertification, contact us. You, your physician or the facility must call us within these timelines:

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency admission</td>
<td>Call at least 14 days before the date you are scheduled to be admitted</td>
</tr>
<tr>
<td>Emergency admission</td>
<td>Call within 48 hours or as soon as reasonably possible after you have been admitted</td>
</tr>
<tr>
<td>Urgent admission</td>
<td>Call before you are scheduled to be admitted</td>
</tr>
<tr>
<td>Outpatient non-emergency medical services</td>
<td>Call at least 14 days before the care is provided, or the treatment or procedure is scheduled</td>
</tr>
</tbody>
</table>

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your physician in writing of the precertification decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient stay in a facility, we will tell you, your physician and the facility about your precertified length of stay. If your physician recommends that you stay longer, the extra days will need to be precertified. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days.

If you or your provider request precertification and we don’t approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the Complaints, claim decisions and appeal procedures section.

Types of services that require precertification

Precertification is required for the following types of services and supplies:

<table>
<thead>
<tr>
<th>Inpatient services and supplies</th>
<th>Outpatient services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stays in a hospital</td>
<td>Cosmetic and reconstructive surgery</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
<td>Emergency transportation by airplane</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
<td>Transcranial magnetic stimulation (TMS)</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for</td>
<td>Partial hospitalization treatment – mental disorder and substance</td>
</tr>
<tr>
<td>treatment of mental disorders and substance</td>
<td>related disorders treatment diagnoses</td>
</tr>
<tr>
<td>related disorders</td>
<td></td>
</tr>
<tr>
<td>Obesity surgery (bariatric)</td>
<td></td>
</tr>
</tbody>
</table>

Contact us to get a list of the services that require precertification. The list may change from time to time.]

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

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these prescription drugs:

For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary.

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.

Contact us or go online to get the most up-to-date precertification requirements and list of step therapy drugs.

Requesting a medical exception
Sometimes you or your provider may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your provider can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your provider 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.

What the plan pays and what you pay
Who pays for your covered services – this plan, both of us, or just you? That depends.

The general rule
The schedule of benefits lists what you pay for each type of covered service. In general, this is how your benefit works:

- You pay the deductible, when it applies.
- Then the plan and you share the expense. Your share is called a copayment or .
- 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, and allowable amount for an out-of-network provider.
**Negotiated charge**

*For health coverage:*

This is the amount a network provider has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

Some providers are part of Aetna’s network for some Aetna plans but are not considered network providers for your plan. For those providers, the negotiated charge is the amount that provider has agreed to accept for rendering services or providing prescription drugs to members of your plan.

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

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

Some of these arrangements are called:

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

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

For prescription drug services:

When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

**Allowable amount**

This is the amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all charges above this amount. The allowable amount depends on the geographic area where you get the service or supply. Allowable amount doesn’t apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an out-of-network provider
- Not available from a network provider
- An emergency service

The table below shows the method for calculating the allowable amount for specific services or supplies:

<table>
<thead>
<tr>
<th>Service or supply:</th>
<th>Allowable amount is based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or supplies not mentioned below</td>
<td>105% of Medicare allowed rate</td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>140% of Medicare allowed rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>110% of average wholesale price (AWP)</td>
</tr>
<tr>
<td>Dental expenses</td>
<td></td>
</tr>
</tbody>
</table>

**Important note:**

See Special terms used, below, for a description of what the allowable amount is based on.

If the provider bills less than the amount calculated using a method above, the allowable amount is what the provider bills.
Special terms used:
- Average wholesale price (AWP) is the current average wholesale price of a prescription drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the provider with a reasonable profit. This means for:
  - Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
  - Facilities that don’t report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities
We may adjust the formula as needed to maintain the reasonableness of the allowable amount. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.
- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific provider performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn’t have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable
We may make the following exceptions:
- For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
- Our rate may exclude other payments that CMS may make directly to hospitals or other providers and backdated adjustments
- For anesthesia, our rate may be at least 105% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes
- For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

When the allowable amount is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.

Our reimbursement policies
We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the allowable amount. When we do this, we consider:
- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the provider

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We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren’t appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

**Get the most from your benefits:**
We have online tools to help you decide whether to get care and if so, where. Use the ‘Estimate the Cost of Care’ tool or ‘Payment Estimator’ tool on the Aetna website. The website may contain additional information that can help you determine the cost of a service or supply.

**Paying for covered services – the general requirements**
There are several general requirements for the plan to pay any part of the expense for a covered service. For in-network coverage, they are:

- The service is medically necessary
- You get your care from a network provider
- You or your provider precertifies the service when required

For out-of-network coverage:

- The service is medically necessary
- You get your care from an out-of-network provider
- You or your provider precertifies the service when required

For outpatient prescription drugs, your costs are based on:

- The type of prescription you’re prescribed
- Where you fill the prescription

The plan may make some brand-name prescription drugs available to you at the generic prescription drug cost share.

Generally, your plan and you share the cost for covered services when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- You get services or supplies that are not medically necessary.
- Your plan requires precertification, your physician requests it, we deny it and you get the services without precertification.
- You get care from an out-of-network provider and the provider waives all or part of your cost share.

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 your maximum out-of-pocket limit.

**Where your schedule of benefits fits in**
The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive covered services and any benefit limitations that apply to your plan. It also shows any maximum out-of-pocket limits that apply.
Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like deductibles, copayments and coinsurance.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

**Coordination of benefits**

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “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 government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

**How COB works**

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

**Determining who pays**

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

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

<table>
<thead>
<tr>
<th>COB rule</th>
<th>Primary Plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-dependent or dependent</td>
<td>Plan covering you as an employee, retired employee or subscriber (not as a dependent)</td>
<td>Plan covering you as a dependent</td>
</tr>
<tr>
<td>COB rule</td>
<td>Primary Plan</td>
<td>Secondary plan</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Child — parents married or living together</td>
<td>Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)</td>
<td>Plan of parent whose birthday is later in the year</td>
</tr>
<tr>
<td>Child — parents separated, divorced, or not living together</td>
<td>• Plan of parent responsible for health coverage in court order&lt;br&gt;• Birthday rule applies if both parents are responsible or have joint custody in court order&lt;br&gt;• Custodial parent’s plan if there is no court order</td>
<td>• Plan of other parent&lt;br&gt;• Birthday rule applies (later in the year)&lt;br&gt;• Non-custodial parent’s plan</td>
</tr>
<tr>
<td>Child — covered by individuals who are not parents (i.e. stepparent or grandparent)</td>
<td>Same rule as parent</td>
<td>Same rule as parent</td>
</tr>
<tr>
<td>Active or inactive employee</td>
<td>Plan covering you as an active employee (or dependent of an active employee)</td>
<td>Plan covering you as a laid off or retired employee (or dependent of a former employee)</td>
</tr>
<tr>
<td>Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation</td>
<td>Plan covering you as an employee or retiree (or dependent of an employee or retiree)</td>
<td>COBRA or state continuation coverage</td>
</tr>
<tr>
<td>Longer or shorter length of coverage</td>
<td>Plan that has covered you longer</td>
<td>Plan that has covered you for a shorter period of time</td>
</tr>
<tr>
<td>Other rules do not apply</td>
<td>Plans share expenses equally</td>
<td>Plans share expenses equally</td>
</tr>
</tbody>
</table>

**How COB works with Medicare**

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it.

**Effect of prior plan coverage**

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current plan must be offered through the policyholder.

**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.

**Our rights**

We have the right to:
• Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
• Reimburse another health plan that paid a benefit we should have paid
• Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims
A claim is a request for payment that you or your health care provider submits to us when you want or get covered services. There are different types of claims. You or your provider may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within How your plan works. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes
Urgent care claim
An urgent claim is one for which the doctor treating you decides a 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. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 24 hours.

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. We will make a decision within 15 days.

Post-service claim
A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension
A concurrent care claim extension occurs when you need 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. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occur 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.

During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance 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.

Filing a claim
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When you see a network provider, that office will usually send us a detailed bill for your services. If you see an out-of-network provider, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, providers and cost of your services.

The benefit payment determination is made based on many things, such as your deductible or coinsurance, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your provider for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the Complaints, claim decisions and appeal procedures section for that information.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint
You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you 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.

Appeal
When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures
Your provider may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in Benefit payments and claims in the How your plan works section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal
If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for
a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal
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 the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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 you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

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

- Contact the Guam Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Guam Department of Insurance
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the state. 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

Utilization review
Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your provider or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing provider or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

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.
Eligibility, starting and stopping coverage

Eligibility
Who is eligible
The policyholder decides and tells us who is eligible for health care coverage.

When you can join the plan
You can enroll:
- Once each year during the annual enrollment period
- At other special times during the year (see the Special times you can join the plan section below)

You can enroll eligible family members (these are your “dependents”) at this time too.

Who can be a dependent on this plan
You can enroll the following family
- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    o Under 26 years of age
  - Dependent children include:
    o Natural children
    o Stepchildren
    o Adopted children including those placed with you for adoption
    o Children you are responsible for under a qualified medical support order or court order

Adding new dependents
You can add new dependents during the year. These include any dependents described in the Who can be a dependent on this plan section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:
- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 after the event date.

Special times you and your dependents can join the plan
You can enroll in these situations:
- You didn’t enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:
• You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
• You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status
Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:
• Change of address
• Dependent status change
• Dependent who enrolls in Medicare or any other health plan

Starting Coverage
Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

Stopping Coverage
Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the Special coverage options after your coverage ends section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end
Your coverage under this plan will end if:
• This plan is no longer available
• You ask to end coverage
• The policyholder asks to end coverage
• You are no longer eligible for coverage, including when you move out of the service area
• Your work ends
• You stop making required contributions, if any apply
• We end your coverage
• You start coverage under another medical plan offered by your employer
• You have reached your overall maximum benefit under your plan

When dependent coverage ends
Dependent coverage will end if:
• A dependent is no longer eligible for coverage.
• You stop making premium contributions, if any apply.
• Your coverage ends for any of the reasons listed above except:
  – Exhaustion of your overall maximum benefit.
  – You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
• Your dependent has exhausted the maximum benefit under your medical plan.
• The date this plan no longer allows coverage for domestic partners or civil unions.
• The date the domestic partnership or civil union ends.
  – You will need to complete a Declaration of Termination of Domestic Partnership.
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 coverage ends section for more information.

Why would we end your coverage?
We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

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

Special coverage options after your coverage ends
When coverage may continue under the plan
This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is the policyholder’s responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

How can you extend coverage if you are totally disabled when coverage ends?
Your coverage may be extended if you 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 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 plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their 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 when getting inpatient care when coverage ends?
Your coverage may be extended if you are getting inpatient care in a hospital or skilled nursing facility when coverage ends.

Benefits are extended for the condition that caused the hospital or skilled nursing facility stay or for complications from the condition. Benefits aren’t extended for other medical conditions.

You can continue to get care for this condition until the earliest of:
• When you are discharged
• When you no longer need inpatient care
• When you become covered by another health benefits plan
• 12 months of coverage

How can you extend coverage for hearing services and supplies when coverage ends?
If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:
• If the prescription for the hearing aid is written during the 30 days before your coverage ends
• If the hearing aid is ordered during the 30 days before your coverage ends

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 provisions
How you and we will interpret this certificate
We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this certificate when we administer your coverage.

How we administer this plan
We apply policies and procedures we’ve developed to administer this plan.

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 policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only we 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 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 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 Complaints, claim decisions and appeal procedures section. You cannot take any action until 60 days after we receive written submission of a 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 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. Important things to keep are:
- Names of physicians 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 policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution 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
- 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 advance 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 ERO

Some other money issues

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. To the extent allowed by law, we will not accept an assignment to an out-of-network provider.

Financial sanctions exclusions
If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for covered 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.

Premium contribution
Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments
We sometimes pay too much for covered services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid, you or your provider, to return what we paid. If we don’t do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured
If someone else caused you to need care — say, a careless driver who injured you in a car crash — you may have a right to get money. We are entitled to that money, up to the amount we pay for your care. We have that right no matter whom the money comes from — for example, the other driver, the policyholder, or another insurance company.

To help us get paid back, you are doing these things now:
- Agreeing to repay us from money you receive because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you’ll tell us within 30 days of when you seek money for your injury or illness. You’ll hold any money you receive until we are paid in full. And you’ll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We don’t have to reduce the amount we’re due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery.
Your health information
We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our *Notice of Privacy Practices*. Just contact us.

When you accept coverage under this plan, you agree to let your *providers* share information with us. We need information about your physical and mental condition and care.

**Effect of benefits under other plans**
Glossary

Allowable amount
See How your plan works – What the plan pays and what you pay.

Behavioral health provider
A health professional who is properly licensed or certified to provide covered services for mental health and substance related disorders in the state where the person practices.

Brand-name prescription drug
An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance
A percentage paid by a covered person for a covered service.

Copay/copayments
A dollar amount or percentage paid by a covered person for a covered service.

Covered service
The benefits, subject to varying cost shares, covered in this plan. These are:
- Described in the Providing covered services section
- Not listed as an exclusion in the Coverage and exclusions – Providing covered services section or the General plan exclusions section
- Not beyond any limits in the schedule of benefits
- Medically necessary. See the How your plan works – Medical necessity, referral and precertification requirements section and the Glossary for more information

Deductible
The amount a covered person pays for covered services per year before we start to pay.

Detoxification
The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Drug guide
A list of prescription drugs and devices established by us or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to https://www.aetna.com/individuals-families/find-a-medication.html.

Emergency medical condition
A severe medical condition that:
- Comes on suddenly
- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
- Loss of function to a body part or organ
- Danger to the health of an unborn baby

Emergency services
Treatment given in a hospital's emergency room. This includes evaluation of and treatment to stabilize the emergency medical condition.

Experimental or investigational
Drugs, treatments or tests not yet accepted by physicians or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is experimental or investigational if:
- 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
An FDA-approved drug with the same intended use as the brand-name product. It offers the same:
- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional
A person who is authorized by law to provide health care services to the public; for example, physicians, nurses and physical therapists.

Home health care agency
An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital
An institution licensed as a hospital by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All hospitals must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.
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

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
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Lifetime maximum
The most this plan will pay for covered services incurred by a covered person during their lifetime.

Mail order pharmacy
A pharmacy where prescription drugs are legally dispensed by mail or another carrier.

Medically necessary/medical necessity
Health care services that we determine 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 we determine 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
- Following the standards set forth in our clinical policies and applying clinical judgment

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

Negotiated charge
See How your plan works – What the plan pays and what you pay.
Network provider
A provider listed in the directory for your plan. A NAP provider listed in the NAP directory is not a network provider. A network provider can also be referred to as an in-network provider.

Out-of-network provider
A provider who is not a network provider.

Physician
A health professional trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a physician can also be a primary care physician (PCP).

Pre-certification, pre-certify
Pre-approval that you or your provider receives from us before you receive certain covered services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Prescription drug
This is an instruction written by a physician that authorizes a patient to receive a service, supply, medicine or treatment.

Provider(s)
A physician, health professional, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don’t participate in Medicare.

Psychiatric hospital
An institution licensed or certified as a psychiatric hospital by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or mental disorders (including substance related disorders).

Residential treatment facility
An institution specifically licensed as a residential treatment facility by applicable laws to provide for mental health or substance related disorder residential treatment programs. It is credentialed by us 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/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)
For substance related 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
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

For detoxification programs within a residential setting:
- An R.N. must be onsite 24 hours/day for 7 days/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, we 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 laws to provide skilled nursing care.
Skilled nursing facilities also include:
- Rehabilitation hospitals
- Portions of a rehabilitation hospital
- A hospital designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance related disorders.

Skilled nursing services
Services provided by a registered nurse or licensed practical nurse 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 contact us to access the list of specialty drugs.
Specialty pharmacy
This is a pharmacy designated by us 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 are excluded from coverage, unless a first-line therapy drug is used first by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request or on our website at https://www.aetna.com/individuals-families/find-a-medicatiography.html.

Substance related disorder
This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

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
- 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 that can be provided electronically by:
- Two-way audiovisual teleconferencing
- Telephone calls
- Any other method required by law

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Urgent condition
An illness or injury that requires prompt medical attention but is not a life-threatening emergency medical condition.
Walk-in clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

Government of Guam

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the
person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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.

Confidentiality Notice
Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.
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.
Schedule of Benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

Prepared exclusively for:
Policyholder: Government of Guam
Policyholder number: 142939
Plan Name: SOB-3A/HSA 2000
Group policy effective date: October 1, 2019
Plan effective date: October 1, 2019
Plan issue date: October 1, 2019

Underwritten by Aetna Life Insurance Company in Guam
Schedule of benefits

This schedule of benefits (schedule) lists the deductibles, copayments or coinsurance, if any apply to the covered services you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The deductibles and copayments, if any, listed in the schedule below are the amounts that you pay for covered services.
  - For the covered services under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a copayment, you will be responsible for the percentage amount
- Coinsurance amounts, if any, listed in the schedule below are what the plan will pay for covered services.
- Sometimes your cost share shows a combination of your dollar amount copayment that you will be responsible for and the coinsurance percentage that your plan will pay.
- You are responsible to pay any deductibles, copayments and remaining coinsurance, if they apply and before the plan will pay for any covered services.
- This plan doesn’t cover every health care service. You pay the full amount of any health care service you get that is not a covered service.
- This plan has limits for some covered services. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-network and out-of-network providers
  - Separate limits for in-network and out-of-network providers
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan
See the schedule of benefits for more information about limits.
- Your cost share may vary if the covered service is preventive or not. Ask your physician or contact us if you have a question about what your cost share will be.

For examples of how cost share and deductible work, go to the Using your Aetna benefits section under Individuals & Families at https://www.aetnainternational.com/.

Important note:
Covered services are subject to the Plan Year deductible, maximum out-of-pocket, limits, copayment or coinsurance unless otherwise stated in this schedule of benefits.

All services outside of Guam, including the USA Mainland and Hawaii require pre-authorization. Services which are not approved through the pre-authorization process are not covered under your plan.

Under this plan, you will:
1. Pay your copayment
2. Then pay any remaining deductible
3. Then pay your coinsurance
Your copayment does not apply to any deductible.

How your deductible works
The deductible is the amount you pay for covered services each year before the plan starts to pay. This is in addition to any copayment or coinsurance you pay when you get covered services from an in-network, out-of-

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network provider. This schedule of benefits shows the deductible amounts that apply to your plan. Once you have met your deductible, we will start sharing the cost when you get covered services. You will continue to pay copayments or coinsurance, if any, for covered services after you meet your deductible.

How your PCP or physician office visit cost share works
You will pay the PCP cost share when you get covered services from any PCP.

How your maximum out-of-pocket works
This 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 services for the remainder of that year.

Contact us
We are here to answer questions. See the Contact us section in your certificate.

Aetna Life Insurance Company’s group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features
Precertification covered services reduction
This only applies to out-of-network covered services:
Your certificate contains a complete description of the precertification process. You will find details in the Medical necessity, referral and precertification section.

If precertification for covered services isn’t completed, when required, it can result in any of the following benefit reductions:
- A $400 benefit reduction applied separately to each type of covered service
- The service is not covered

You may have to pay an additional portion of the allowable amount because you didn’t get precertification. This portion is not a covered service and doesn’t apply to your deductible or maximum out-of-pocket limit, if you have one.

Deductible
You have to meet your deductible before this plan pays for benefits.

<table>
<thead>
<tr>
<th>Deductible type</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000 per year</td>
<td>$4,000 per year</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000 per year</td>
<td>$12,000 per year</td>
</tr>
</tbody>
</table>

Deductible waiver
There is no in-network deductible for the following covered services:
- Preventive care

Maximum out-of-pocket limit
<table>
<thead>
<tr>
<th>Maximum out-of-pocket type</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$4,000 per year</td>
<td>$0 per year</td>
</tr>
<tr>
<td>Family</td>
<td>$12,000 per year</td>
<td>$0 per year</td>
</tr>
</tbody>
</table>

General coverage provisions
This section explains the deductible, maximum out-of-pocket limit and limitations listed in this schedule.

Deductible provisions
Covered services that are subject to the deductible include those provided under the medical plan and the prescription drug plan.

The deductible may not apply to some covered services. You still pay the copayment or coinsurance, if any, for these covered services.

Individual deductible
You pay for covered services each year before the plan begins to pay. This individual deductible applies separately to you and each covered dependent. After the amount paid reaches the individual deductible, this plan starts to pay for covered services for the rest of the year.

Family deductible
You pay for covered services each year before the plan begins to pay. After the amount paid for covered services reaches this family deductible, this plan starts to pay for covered services for the rest of the year. To satisfy this family deductible for the rest of the year, the combined covered services that you and each of your covered dependents incur toward the individual deductible must reach this family deductible in a year. When this happens in a year, the individual deductibles for you and your covered dependents are met for the rest of the year.

Copayment
This is a dollar amount or percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

Coinsurance
This is a percentage you pay for a covered service. This is in addition to any out-of-pocket costs you have to pay to meet your deductible, if you have one.

Individual maximum out-of-pocket limit
- This plan may have an individual and family maximum out-of-pocket limit. As to the individual maximum out-of-pocket limit, each of you must meet your maximum out-of-pocket limit separately.
- After you or your covered dependents meet the individual maximum out-of-pocket limit, this plan will pay 100% of the eligible charge for covered services that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit
After you or your covered dependents meet the family maximum out-of-pocket limit, this plan will pay 100% of the eligible charge for covered services that would apply toward the limit for the remainder of the year for all
covered family members. The family maximum out-of-pocket limit is a cumulative maximum out-of-pocket limit for all family members.

To satisfy this maximum out-of-pocket limit for the rest of the year, the following must happen:
- The family maximum out-of-pocket limit is met by a combination of family members
- No one person within a family will contribute more than the individual maximum out-of-pocket limit amount in a year

If the maximum out-of-pocket limit does not apply to a covered service, your cost share for that service will not count toward satisfying the maximum out-of-pocket limit amount.

Certain costs that you have do not apply toward the maximum out-of-pocket limit. These include:
- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the allowable amount

Limit provisions
Covered services applied to the in-network limit will not apply to the out-of-network limit. Covered services applied to the out-of-network limit will not apply to the in-network limit.

Your financial responsibility and decisions regarding benefits
We base your financial responsibility for the cost of covered services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.
## Covered services

### Acupuncture

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

| Visit limit per year | 30 | 30 |

### Ambulance services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>80% per trip after deductible</td>
<td>Paid same as in-network</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency services</td>
<td>80% per trip after deductible</td>
<td>80% per trip after deductible</td>
</tr>
</tbody>
</table>

### Applied behavior analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied behavior analysis</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
### Autism spectrum disorder

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and testing</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Treatment</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Clinical trials

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental or investigational therapies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Routine patient costs</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Diabetic services, supplies, equipment, and self-care programs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic services</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Diabetic equipment</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Diabetic self-care programs</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
### Durable medical equipment (DME)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME</td>
<td>80% per item after deductible</td>
<td>50% per item after deductible</td>
</tr>
<tr>
<td>Limit per year</td>
<td>unlimited</td>
<td>unlimited</td>
</tr>
</tbody>
</table>

### Emergency services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room</td>
<td>80% (per visit after deductible)</td>
<td>Paid same as in-network</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>50% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

**Emergency services important note:**

Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.

### Habilitation therapy services

**Physical, occupational and speech therapies**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT, OT, ST therapies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Hearing aids

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids</td>
<td>80% per item after deductible</td>
<td>50% per item after deductible</td>
</tr>
<tr>
<td>Limit</td>
<td>One per ear every plan year</td>
<td>One per ear every plan year</td>
</tr>
<tr>
<td>Limit</td>
<td>$500</td>
<td>$500</td>
</tr>
</tbody>
</table>

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### Hearing exams

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing exams</td>
<td>Covered based on type of service and where it is received</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limit</td>
<td>One every 24 months</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Home health care

A visit is a period of 4 hours or less.

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

Visit limit per year

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit limit per year</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

**Home health care important note:**

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

### Hospice care

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - room and board</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
</tr>
<tr>
<td>Day limit per lifetime</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services</td>
<td>100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>
**Hospice important note:**
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

**Hospital care**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
</tr>
</tbody>
</table>

**Infertility services**

**Basic infertility**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of basic infertility</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Maternity and related newborn care**

Includes complications

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
</tr>
<tr>
<td>Services performed in physician or specialist office or a facility</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Other services and supplies</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**Maternity and related newborn care important note:**
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the **Maternity** section of the certificate. It will give you more information about coverage for maternity care under this plan.
Mental health treatment
Coverage provided is the same as for any other illness

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services-room and board including residential treatment facility</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
</tr>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Includes telemedicine consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health telemedicine consultations by a physician or behavioral health provider</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Other outpatient services including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health services in the home</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>• Partial hospitalization treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive outpatient program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The cost share doesn’t apply to in-network peer counseling support services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Obesity surgery**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Limit per lifetime</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

**Oral and maxillofacial treatment (mouth, jaws and teeth)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of mouth, jaws and teeth</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Outpatient prescription drugs**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs</td>
<td>50% per supply after deductible</td>
</tr>
</tbody>
</table>

**Outpatient prescription drugs**

**Preferred generic prescription drugs**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$15 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$15 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Preferred brand-name prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$30 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$30 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Non-preferred generic prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$100 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$100 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Non-preferred brand-name prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$100 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail pharmacy</td>
<td>$100 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply at a mail order pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Specialty prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a specialty pharmacy or retail pharmacy</td>
<td>$100 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Anti-cancer drugs taken by mouth

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Each 30 day supply up to 12 months at a retail or mail order pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Insulin

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply at a retail or mail order pharmacy</td>
<td>$0 after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Outpatient surgery

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>At hospital outpatient department</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Physician office hours (not-surgical, not preventive)</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Physician surgical services</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Specialist office hours (not-surgical, not preventive)</td>
<td>$40 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Specialist surgical services</td>
<td>$40 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>All other services</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
<td>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunizations limit</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine physical exam</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine physical exam limits</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well woman GYN exam</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Well woman GYN exam limit</td>
<td>Subject to any age and visit limits provided for in the comprehensive</td>
<td>Subject to any age and visit limits provided for in the comprehensive</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td><strong>In-Network (Participating)</strong> Inside &amp; Outside of Guam</td>
<td><strong>Out-of-Network (Non-Participating)</strong> Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Description</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reconstructive surgery and supplies**
Including breast surgery

<table>
<thead>
<tr>
<th>Description</th>
<th><strong>In-Network (Participating)</strong> Inside &amp; Outside of Guam</th>
<th><strong>Out-of-Network (Non-Participating)</strong> Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery and supplies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Routine cancer screenings**

<table>
<thead>
<tr>
<th>Description</th>
<th><strong>In-Network (Participating)</strong> Inside &amp; Outside of Guam</th>
<th><strong>Out-of-Network (Non-Participating)</strong> Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>100% per test, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Digital rectal examination (DRE)</td>
<td>100% per exam, no deductible applies</td>
<td>70% per exam after deductible</td>
</tr>
<tr>
<td>Double contrast barium enema (DCBE)</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Fecal occult blood test (FOBT)</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Mammogram</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) test</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>100% per test, no deductible applies</td>
<td>70% per test after deductible</td>
</tr>
<tr>
<td>Cancer screening limits</td>
<td>Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items</td>
<td>Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items</td>
</tr>
</tbody>
</table>
that have a rating of A or B in the current recommendations of the USPSTF

The comprehensive guidelines supported by the Health Resources and Services Administration

For more information contact your physician or see the Contact us section

**Short-term rehabilitation services**

**Cardiac rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Pulmonary rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Cognitive rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td>Description</td>
<td>In-Network (Participating) Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>PT, OT and ST</td>
<td>$40 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical, Occupational and Speech Therapies</th>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit limit per year</td>
<td>60</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spinal Manipulation</th>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Manipulation</td>
<td>$40 then the plan pays 100% per visit after deductible</td>
<td>75% per visit after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skilled nursing facility</th>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - room and board</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
<td></td>
</tr>
</tbody>
</table>

| Day limit per year | 60 | 60 |

<table>
<thead>
<tr>
<th>Substance related disorders treatment</th>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services-room and board during a hospital stay</td>
<td>80% per admission after deductible</td>
<td>50% per admission after deductible</td>
<td></td>
</tr>
</tbody>
</table>

Includes detoxification, rehabilitation and residential treatment facility
Coverage provided is the same as for any other illness
<table>
<thead>
<tr>
<th>Description</th>
<th>(Participating) Inside &amp; Outside of Guam</th>
<th>(Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Includes telemedicine consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient telemedicine cognitive therapy consultations by a physician or</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>behavioral health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other outpatient services including:</td>
<td>80% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>• Behavioral health services in the home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial hospitalization treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive outpatient program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The cost share doesn’t apply to in-network peer counseling support services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tests, images and labs – outpatient
Diagnostic complex imaging services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
<td></td>
</tr>
</tbody>
</table>
### Diagnostic lab work

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

### Diagnostic x-ray and other radiological services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

### Therapies

#### Chemotherapy

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Infusion therapy

#### Outpatient services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Radiation therapy

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation therapy</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
## Respiratory therapy

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory therapy</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

## Transplant services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network (IOE facility) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-IOE Facility) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services and supplies</td>
<td>80% per transplant after deductible</td>
<td>50% per transplant after deductible</td>
</tr>
<tr>
<td>Physician services</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

## Description

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care facility</td>
<td>$50 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
<tr>
<td>Non-urgent use of an urgent care facility or provider</td>
<td>50% per visit after deductible</td>
<td>50% per visit after deductible</td>
</tr>
</tbody>
</table>

## Vision care

Performed by an ophthalmologist or optometrist and includes refraction

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% per visit after, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

| Visit limit | 1 visit every 12 months | Not covered |

AI GU HSASOB 142939 22
<table>
<thead>
<tr>
<th>Walk-in clinic</th>
<th></th>
<th>In-Network (Participating) Inside &amp; Outside of Guam</th>
<th>Out-of-Network (Non-Participating) Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td></td>
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<tr>
<td>Non-emergency services</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
<td></td>
</tr>
<tr>
<td>Preventive immunizations</td>
<td>$20 then the plan pays 100% per visit after deductible</td>
<td>50% per visit after deductible</td>
<td></td>
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<tr>
<td>Immunization limits</td>
<td>Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
<td>Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
<td>For details, contact your physician</td>
</tr>
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<td>For details, contact your physician</td>
<td></td>
<td>For details, contact your physician</td>
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</tbody>
</table>
BENEFIT PLAN

Prepared Exclusively For
Government of Guam

Basic Vision

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan Covers and How Benefits are Paid

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder.

♥aetna™
Vision Plan

Booklet-Certificate

Prepared exclusively for:
Policyholder: Government of Guam
Group policy number: GP-142939
Booklet-certificate 2
Group policy effective date: October 1, 2019
Plan issue date: October 1, 2019

Underwritten by Aetna Life Insurance Company in Guam
Welcome

Thank you for choosing Aetna.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your Aetna plan.

This booklet-certificate will tell you about your covered benefits – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the group policy, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for eligible vision services and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the group policy between Aetna Life Insurance Company (Aetna) and your policyholder. Ask the policyholder if you have any questions about the group policy.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they’re part of. When you receive these, they are considered part of your Aetna plan for coverage.

Where to next? Try the Let’s get started! section. Let’s get started! gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Aetna plan.
<table>
<thead>
<tr>
<th>Table of Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
</tr>
<tr>
<td>Let's get started!</td>
</tr>
<tr>
<td>Some notes on how we use words</td>
</tr>
<tr>
<td>What your plan does—providing covered benefits</td>
</tr>
<tr>
<td>How your plan works—starting and stopping coverage</td>
</tr>
<tr>
<td>How your plan works while you are covered</td>
</tr>
<tr>
<td>How to contact us for help</td>
</tr>
<tr>
<td>Who the plan covers</td>
</tr>
<tr>
<td>Who is eligible</td>
</tr>
<tr>
<td>When you can join the plan</td>
</tr>
<tr>
<td>Adding new dependents</td>
</tr>
<tr>
<td>Special times you and your dependents can join the plan</td>
</tr>
<tr>
<td>Effective date of coverage</td>
</tr>
<tr>
<td>Eligible vision services under your plan</td>
</tr>
<tr>
<td>What your plan doesn't cover—eligible vision service exclusions</td>
</tr>
<tr>
<td>Who provides the care</td>
</tr>
<tr>
<td>What the plan pays and what you pay</td>
</tr>
<tr>
<td>Special financial responsibility</td>
</tr>
<tr>
<td>When you disagree—claim decisions and appeals procedures</td>
</tr>
<tr>
<td>Communicating our claim decisions</td>
</tr>
<tr>
<td>Adverse benefit determinations</td>
</tr>
<tr>
<td>The difference between a complaint and an appeal</td>
</tr>
<tr>
<td>Appeals of adverse benefit determinations</td>
</tr>
<tr>
<td>Timeframes for deciding appeals</td>
</tr>
<tr>
<td>Exhaustion of appeals process</td>
</tr>
<tr>
<td>Recordkeeping</td>
</tr>
<tr>
<td>Fees and expenses</td>
</tr>
<tr>
<td>When coverage ends</td>
</tr>
<tr>
<td>When will your coverage end?</td>
</tr>
<tr>
<td>When will coverage end for any dependents?</td>
</tr>
<tr>
<td>Why would we end you and your dependents coverage?</td>
</tr>
<tr>
<td>Special coverage options after your plan coverage ends</td>
</tr>
<tr>
<td>Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights</td>
</tr>
<tr>
<td>Continuation of coverage for other reasons</td>
</tr>
<tr>
<td>General provisions—other things you should know</td>
</tr>
<tr>
<td>Administrative provisions</td>
</tr>
<tr>
<td>Coverage and services</td>
</tr>
<tr>
<td>Honest mistakes and intentional deception</td>
</tr>
<tr>
<td>Some other money issues</td>
</tr>
<tr>
<td>Glossary</td>
</tr>
</tbody>
</table>

Schedule of benefits Issued with your booklet-certificate
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-certificate 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.
- Some words appear in bold type. We define them in the Glossary section.

Sometimes we use technical vision language that is familiar to vision providers.

What your plan does – providing covered benefits

Your plan provides covered benefits. These are eligible vision services. Your plan has an obligation to pay for eligible vision services.

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
Your plan provides covered benefits. These are eligible vision services. Your plan has an obligation to pay for eligible vision services.

1. Eligible vision services
   So what are eligible vision services? They are vision care services that meet these three requirements:
   • They appear in the Eligible vision services under your plan section.
   • They are not listed in the What your plan doesn’t cover – eligible vision service exclusions section.
   • They are not beyond any limits in the schedule of benefits.

2. Providers
   You may choose any vision provider for the care you need.
   For more information about the role of your vision provider, see the Who provides the care section.

3. Paying for eligible vision services—sharing the expense
   Generally your plan and you will share the expense of your eligible vision services when you meet the general requirements for paying.
   But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the What the plan pays and what you pay section, and see the schedule of benefits.

How to contact us for help
We are here to answer your questions. You can contact us by:
   • Logging onto your secure member website at www.aetnainternational.com.
   • Register for our secure Internet access to reliable vision information, tools and resources

Online tools will make it easier for you to make informed decisions about your vision care, view claims, research care and treatment options, and access information.

You can also contact us by:
   • Calling Aetna Member Services
   • Writing us at Aetna Life Insurance Company, 151 Farmington Ave, Hartford, CT 06156

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
Your policyholder decides and tells us who is eligible for vision care coverage.
When you can join the plan
As an employee you can enroll yourself and your dependents:
- At any time
- Once each Plan 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 and your dependents when you first qualify for vision 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)
If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are your “dependents”.)
- Your legal spouse
- Your domestic partner who meets the rules set by the policyholder and requirements under state law
- Your dependent children -- your own or those of your spouse or domestic partner
  - Under age 26, as long as they solely depend on your support and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)

Important note:
You may continue coverage for a disabled child past the age limit shown above. See the Continuation of coverage for other reasons in the Special coverage options after your plan coverage ends section for more information.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.
Adding new dependents
You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of
    your marriage.
  - Ask your policyholder when benefits for your spouse will begin:
    o If we receive your completed enrollment information by the 15th of the month, coverage will be
      effective no later than the first day of the following month
    o If we received your completed enrollment information between the 16th and the last day of the
      month, coverage will be effective no later than the first day of the second month

- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your
  plan. See Who can be on your plan (Who can be a dependent) section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you
    file a Declaration of Domestic Partnership, or not later than 31 days after you provide
    documentation required by your policyholder.
  - Ask your policyholder when benefits for your domestic partner will begin. It will be on the date your
    Declaration of Domestic Partnership is filed or the first day of the month following the qualifying
    event date.

- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan from
  the moment of birth and for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60
    days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment
    of an additional premium contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.

- An adopted child - See Who can be on your plan (who can be a dependent) section for more information.
  An adopted child is covered on your plan for the first 60 days after the adoption is complete or the date
  the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal
  obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information
    within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.

- A foster child - A foster child is covered on your plan for the first 31 days after obtaining legal
  responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing
  is left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within
    60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.

- A step child – You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of
    your marriage or Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask your policyholder when benefits for your stepchild will begin. It is the date of your marriage,
    Declaration of Domestic Partnership or the first day of the month following the qualifying event
date.
Inform us of any changes
It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group vision plan

Special times you and your dependents can join the plan
You can enroll in these situations when:

- You have added a dependent because of marriage, birth, adoption or foster care. See the Adding new dependents section for more information.
- You become a citizen, national or lawfully present in the United States.
- You did not enroll in this plan before because:
  - You were covered by another group vision plan, and now that other coverage has ended
  - You had COBRA, and now that coverage has ended
- A court orders you cover a current spouse, domestic partner or a child on your vision plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above.

Effective date of coverage
Your coverage will be in effect on the first date of the month based on when we receive your completed enrollment application.
Eligible vision services under your plan

Eligible vision services include services provided by an ophthalmologist or optometrist.

You may get vision services and supplies from any vision providers. Refer to your schedule of benefits for more information.

You may use vision providers of your choice for eligible vision services and supplies under this plan.

Vision care services and supplies
Eligible vision services and supplies include those prescribed for the first time and those required because of a change in prescription. These include:

• Eyeglass frames, prescription lenses or prescription contact lenses that are identified by a vision provider
• Aphakic lenses prescribed after cataract surgery
• Contact lenses required to correct visual acuity to 20/40 or better in the better eye if such correction cannot be made with conventional lenses

What your plan doesn’t cover – eligible vision service exclusions

We already told you about the many vision care services and supplies that are eligible for coverage under your plan in the Eligible vision services under your plan section. In that section we also told you that some vision care services and supplies have exclusions. For example, cosmetic surgery is never covered. This is an exclusion.

In this section we tell you about the exclusions that apply to your plan.

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

Exclusions
The following are not eligible vision services under your plan except as described in the Eligible vision services under your plan section of this booklet-certificate, or by a rider or amendment included with this certificate:

Cornea transplants
• Cornea (corneal graft with amniotic membrane)

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.

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
Examinations
Any vision examinations needed:
- During your stay in a hospital or other facility for medical care
- For the purpose of the fitting of contact lenses
- 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

Laser in-situ keratomileusis (LASIK)
- Including related procedures designed to surgically correct refractive errors

Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision)

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

Personal care, comfort or convenience items
- Any service or supply primarily for your convenience and personal comfort or that of a third party

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

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 services and supplies
- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any vision examination, or any corrective eyewear required by a policyholder as a condition of employment, and safety eyewear
- Services provided as a result of any workers’ compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Services rendered after the date a member ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured member are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care
Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible vision services. This section tells you about vision providers.

Vision providers
When you need vision supplies, you can go to any vision provider to provide eligible vision services and supplies to you.

You may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible vision services that you paid directly to a vision provider.

We will tell you what we have paid for eligible vision services and supplies. It will tell you if you owe any amounts or if any services or supplies are not covered. You can receive this from us by e-mail or through the mail.

What the plan pays and what you pay

Who pays for your eligible vision services – this plan, both of us, or just you? That depends. This section gives the general rule and explains your vision supply maximums listed in your schedule of benefits

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 vision service.

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 any maximum

Where your schedule of benefits fits in
How your vision supply maximum works
The maximum is the most your plan will pay for eligible vision services incurred by a covered person per 12 consecutive month period. You are responsible for any amounts above the maximum.

Important note:
See the schedule of benefits for maximums that apply.
When you disagree - claim decisions and appeals procedures

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

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

Claim procedures
You or your vision provider are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the vision provider or to you as appropriate.

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from us.</td>
<td>• You must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to</td>
<td>• If you are unable to complete a claim form, you may send us:</td>
</tr>
<tr>
<td></td>
<td>send the form(s)</td>
<td>− A description of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Bill of charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Any vision documentation you received from your vision provider</td>
</tr>
<tr>
<td>Proof of claim</td>
<td>• A completed claim form and any additional information required by</td>
<td>• You must send us notice and proof as soon as reasonably possible</td>
</tr>
<tr>
<td></td>
<td>us.</td>
<td></td>
</tr>
<tr>
<td>When you have received a</td>
<td></td>
<td></td>
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<tr>
<td>service from an eligible</td>
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<tr>
<td>vision provider, you will</td>
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<td>be charged.</td>
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<td>The information you receive</td>
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<tr>
<td>for that service is your</td>
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<tr>
<td>proof of loss.</td>
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<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits</td>
<td>• Benefits will be paid as soon as the necessary proof to support the</td>
</tr>
<tr>
<td></td>
<td>• If any portion of a claim is contested by us, the uncontested portion</td>
<td>claim is received.</td>
</tr>
<tr>
<td></td>
<td>of the claim will be paid promptly after the receipt of proof of loss.</td>
<td></td>
</tr>
</tbody>
</table>
If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Communicating our claim decisions
The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim
A post service claim is a claim that involves vision care services you have already received.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Post-service claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision by us</td>
<td>30 days</td>
</tr>
<tr>
<td>Extensions</td>
<td>15 days</td>
</tr>
<tr>
<td>If we request more information to help in our review</td>
<td>30 days</td>
</tr>
<tr>
<td>Time you have to send us additional information</td>
<td>45 days</td>
</tr>
</tbody>
</table>

Adverse benefit determinations
Sometimes we pay only some of your 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 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 the address on the notice of adverse benefit determination. Or you can call Member Services. You need to include:

- Your name
- The policyholder’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 vision 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 vision 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.
Timeframes for deciding appeals
The chart below shows a timetable view of the type of notice and how much time we have to tell you about our decision.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Post-service appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision by us</td>
<td>30 days</td>
</tr>
<tr>
<td>Extensions</td>
<td>15 days</td>
</tr>
<tr>
<td>If we request more information</td>
<td>30 days</td>
</tr>
<tr>
<td>Time you have to send us additional information</td>
<td>45 days</td>
</tr>
</tbody>
</table>

Exhaustion of appeals process
In most situations you must complete the one level of appeal with us before you can take these other actions:
- Contact the Guam Department of Insurance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Guam Department of Insurance.
- Pursue arbitration, litigation or other type of administrative proceeding.

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 when you submit a complaint or appeal.

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
- The group policy ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required premium payment
- We end your coverage
- You become covered under another vision plan offered by your policyholder

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 the policyholder and us.

If premium payments are made for you, you may be able to continue to 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 30 months from the start of your absence.

Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.

If premium payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below:
- Your coverage will not continue after the month in which your absence started.

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 premium payments are made for you, you may be able to continue coverage under the plan as long as your policyholder and we agree to do so and as described below:
- Your coverage may continue until stopped by your policyholder but not beyond 30 months from the start of the absence.

Your employment ends because of a leave of absence that is not a medical leave of absence.

If premium payments are made for you, you may be able to continue coverage under the plan as long as your policyholder and we agree to do so and as described below:
- Your coverage will not continue after the month in which your absence started.

Your employment ends because of a military leave of absence.

If premium payments are made for you, you may be able to continue to 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 18 months from the start of the absence.

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and your policyholder agree 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.
- The group policy ends
- You do not make the required premium contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:
- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends.

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 before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

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

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.

Continuation of coverage for other reasons
To request an extension of coverage, just call the toll-free Member Services.

How can you extend coverage for vision care services and supplies when coverage ends?
If your coverage ends while you are not totally disabled, your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:
- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction.
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in prescription.
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.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate
We prepared this booklet-certificate according to ERISA, and according to other federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable authority.

How we administer this plan
We apply policies and procedures we’ve developed to administer this plan.

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 vision providers. They are not our employees or agents.
Coverage and services
Your coverage can change
Your coverage is defined by the group policy. This document may have amendments or riders too. Under certain circumstances, we or your policyholder or the law may change your plan. Only we may waive a requirement of your plan. No other person – including your policyholder or vision 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 your policyholder any unearned premium.

Financial sanctions exclusions:
If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible vision 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.

Legal action
You are encouraged to complete the appeal process before you take any legal action against us for any expense or bill until you complete the appeal process. 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.

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 and vision providers who provide services
- Dates expenses are incurred
- Copies of all bills and receipts
Honest mistakes and intentional deception

Honest mistakes
You or your policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution 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 effects on your coverage. These include, but are not limited to:

- Loss of coverage, starting at some time in the past.
- 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.

Some other money issues

Assignment of benefits
When you see a vision provider they will usually bill us directly. We may choose to pay you or to pay the vision provider directly.

Recovery of overpayments
We sometimes pay too much for eligible vision services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid — you or your vision provider — to return what we paid. If we don’t do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Premium contribution
This plan requires the policyholder to make premium contribution payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if premium contribution payments are not made. Any benefit payment denial is subject to our appeals procedure. See the When you disagree - claim decisions and appeals procedures section.

Payment of premiums
The first premium payment for this policy is due on or before your effective date of coverage. Your next premium payment will be due the 1st of each month ("premium due date"). Each premium payment is to be paid to us on or before the premium due date.
Your vision information
We will protect your vision information. We use and share it to help us process your claims and manage your policy. You can get a free copy of our Notice of Privacy Practices. Just call Member Services. When you accept coverage under this policy, you agree to let your vision providers share your information with us. We will need information about your physical and mental condition and care.

Glossary

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

Calendar Year
A period of 12 months that begins on January 1st and ends on December 31st.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible vision services that meet the requirements for coverage under the terms of this plan.

Effective date of coverage
The date you and your dependent’s coverage begin under this booklet-certificate as noted in our records.

Eligible vision services
The vision care services and supplies listed in the Eligible vision services under your plan section and not listed or limited in the What your plan doesn’t cover—eligible vision service exclusions section or in the schedule of benefits.

Group policy
The group policy consists of several documents taken together. These documents are:

- The group application
- The group policy
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the group policy, the booklet-certificate, and the schedule of benefits

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.

Policyholder
An employer or organization who agrees to remit the premiums for coverage under the group policy payable to Aetna. The policyholder shall act only as an agent of Aetna members in the employer group, and shall not be the agent of Aetna for any purpose.

AI GU BasicVisCOC 142939 22
**Premium**
The amount you or your policyholder are required to pay to Aetna for your coverage.

**Prescription**
A written order for the dispensing of prescription lenses or prescription contact lenses by an ophthalmologist or optometrist.

**Vision provider**
Any individual legally licensed to provide vision services or supplies.
Additional Information Provided by

Government of Guam

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Confidentiality Notice
Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at www.aetna.com.
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.

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Vision Plan

Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:
Policyholder: Government of Guam
Group policy number: GP-142939
Schedule of Benefits 2A
Group policy effective date: October 1, 2019
Plan effective date: October 1, 2019
Plan issue date: October 1, 2019

Underwritten by Aetna Life Insurance Company in Guam.
Schedule of benefits

This schedule of benefits lists the eligible vision services and supplies, 12 consecutive month period maximums, if any, that apply to the services you get under this plan.

How to read your schedule of benefits
- You are responsible for full payment of any vision care services you get that is not a covered benefit
- Exceeds your 12 consecutive month period maximum.

How to contact us for help
We are here to answer your questions.
- Log onto your secure member website at www.aetnainternational.com.
- Call Member Services

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

General coverage provision
This section explains the vision supply maximum listed in this schedule of benefits.

Maximum vision supply
The most the plan will pay for eligible vision services incurred by any one covered person in a 12 consecutive month period is called a vision supply maximum.

Your financial responsibility and determination of benefits provisions
Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan feature

<table>
<thead>
<tr>
<th>Eligible vision services</th>
<th>Maximum benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision care services and supplies</td>
<td>$150 per 12 consecutive month period</td>
</tr>
<tr>
<td>Coverage does not include the office visit for the fitting of prescription contact lenses</td>
<td></td>
</tr>
</tbody>
</table>
Group Insurance Plan of Benefits for
Government of Guam (Control # 142939) – Foster Plan
administered by Aetna International®
Your Plan Effective Date: October 1, 2019

Eligibility Provision
Foster children under the legal custody of the Child Protective Services Division of the Department of Public Health as defined in 4 G.C.A..

All services outside of Guam, including the USA Mainland & Hawaii require pre-authorization

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>PARTICIPATING</th>
<th>NON-PARTICIPATING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Inside &amp; Outside of Guam</td>
<td>Out-of-Network Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>Member Responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$0 per Plan Year</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$0 per Plan Year</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Individual Payment Limit</td>
<td>$0 per Plan Year</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Family Payment Limit</td>
<td>$0 per Plan Year</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

| Hospital Services | | |
|-------------------|-------------------|
| Inpatient Private Room Limit | No Charge | Not Covered |
| Includes Breast Reconstructive Surgery, Cardiac Surgery, Congenital Anomaly Diseases, Elective Surgery, Maternity Care, Robotic Surgery (Pre-Certification may be required) |
| Outpatient | No Charge | Not Covered |
| Includes Ambulatory Surgi-Center Care, Outpatient cataract surgery, Chemotherapy, MRI, CT scan, and other diagnostic procedures, End Stage Renal Disease / Hemodialysis, Nuclear Medicine, Inhalation Therapy, Radiation Therapy, Sleep Apnea, Vasectomy |

| Pre-certification Penalty | No penalty | Not Covered |
| Emergency Room | No Charge | Not Covered |
| Non-Emergency Use of the Emergency Room | No Charge | Not Covered |
| Urgent Care | No Charge | Not Covered |
| Non-Urgent Use of Urgent Care Provider | No Charge | Not Covered |
| Ambulance Services | No Charge | Not Covered |

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Schedule of Benefits and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents. In the event of a discrepancy between the benefit grid and the Contract, between the Government of Guam and Aetna, the contract will prevail.
## Plan Features

<table>
<thead>
<tr>
<th>Member Responsibility</th>
<th>PARTICIPATING</th>
<th>NON-PARTICIPATING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Inside &amp; Outside of Guam</td>
<td>Out-of-Network Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Alcohol/Drug Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Inpatient</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited days per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Outpatient</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited visits per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Inpatient</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited days per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Outpatient</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited visits per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Child Physical Exams</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>7 exams in the first 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, and 1 exam per 12 months thereafter to age 22</td>
<td>Includes Immunizations/vaccinations</td>
<td></td>
</tr>
<tr>
<td>Routine Adult Physical Exams</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older</td>
<td>Includes Immunizations/vaccinations</td>
<td></td>
</tr>
<tr>
<td>Routine Gynecological Exams</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Includes 1 exam and pap smear per Plan Year</td>
<td>Includes sterilization and tubal ligation</td>
<td></td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Digital Rectal Exam (DRE)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Recommended: For all members age 50 and older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Hearing Exams</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Includes one routine exam every 24 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>$500 per member, per plan year</td>
<td></td>
<td></td>
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*Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Schedule of Benefits and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents. In the event of a discrepancy between the benefit grid and the Contract, between the Government of Guam and Aetna, the contract will prevail.*
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<tr>
<td><strong>Member Responsibility</strong></td>
<td>In-Network Inside &amp; Outside of Guam</td>
<td>Out-of-Network Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>60 visits per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care Facility Inpatient</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>30 day Lifetime maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care Facility Outpatient</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>180 day Lifetime maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>120 visits per Plan Year, includes Private Duty Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Disorder Treatment</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited visits per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Term Rehabilitation</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>60 combined visits per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes coverage for Occupational, Physical and Speech Therapies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>30 visits per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Outpatient X-ray</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Diagnostic Outpatient Lab</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited lifetime maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including Orthopedic conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Serum &amp; Injections</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Does not include those on the Specially Drugs List &amp; Orthopedic injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetics Supplies</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Base Infertility Services</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

(Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the coverage administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term “Plan Documents” includes, but is not limited to, the Booklet, Schedule of Benefits and any Booklet Amendments/Riders including any state specific variations, as applicable. For further details, refer to your Plan Documents. In the event of a discrepancy between the benefit grid and the Contract, between the Government of Guam and Aetna, the contract will prevail.)
Group Insurance Plan of Benefits for
Government of Guam (Control # 142939) – Foster Plan
administered by Aetna International®
Your Plan Effective Date: October 1, 2019

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>PARTICIPATING</th>
<th>NON-PARTICIPATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong></td>
<td><strong>In-Network Inside &amp; Outside of Guam</strong></td>
<td><strong>Out-of-Network Inside &amp; Outside of Guam</strong></td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Unlimited lifetime maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Organ Donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aids Treatment</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Precertification Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment for Non-Preferred Providers*</td>
<td>Not Applicable</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Airfare Benefit</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>For members who meet qualifying conditions, Plan provides roundtrip airfare (Plan Approval Required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Autism covered same as any other expense. Member cost sharing is based on the type of service performed and the place of service where it is rendered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Prescription Drugs</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(365 day maximum supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes contraceptives (see note below))</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Eye Exams</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Covered under medical) includes 1 exam every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Care Supplies</td>
<td>No charge up to $150 maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Scheduled maximums apply every 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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# Foster

**Group Insurance Plan of Benefits for**
**Government of Guam (Control # 142939) – Foster Plan**

administered by Aetna International®

Your Plan Effective Date: October 1, 2019

<table>
<thead>
<tr>
<th>Add on Services</th>
<th>Included</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Employee Assistance Program (IEAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International Disease Management</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>International Maternity Management Program</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Simple Steps To A Healthier Life®</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Wellness Checkpoint</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

The proposed plan of benefits is underwritten by Aetna Life Insurance Company. This is only a brief summary of the benefits available. Some restrictions may apply.

For more specific information about the coverage details, including limitations, exclusions and other plan requirements, please refer to the employee booklet (which will be provided near the time the plan becomes effective).

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Group Insurance Plan of Benefits for
Government of Guam (Control # 142939) – RSP Plan
administered by Aetna International®
Your Plan Effective Date: October 1, 2019

<table>
<thead>
<tr>
<th>Eligibility Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees/Survivors</td>
</tr>
<tr>
<td>Dependent</td>
</tr>
</tbody>
</table>

All services outside of Guam, including the USA Mainland & Hawaii and where individual circumstances warrant, services that are necessary and can only be provided by a non-participating provider require pre-authorization.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>PARTICIPATING</th>
<th>NON-PARTICIPATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>In-Network Inside &amp; Outside of Guam</td>
<td>Out-of-Network Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>Individual</td>
<td>$0 per Plan Year</td>
<td>$0 per Plan Year</td>
</tr>
<tr>
<td>Family</td>
<td>$0 per Plan Year</td>
<td>$0 per Plan Year</td>
</tr>
<tr>
<td>Individual Payment Limit</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family Payment Limit</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Private Room Limit</td>
</tr>
<tr>
<td>Includes Breast Reconstructive Surgery, Cardiac Surgery, Congenital Anomaly Diseases, Elective Surgery, Maternity Care, Robotic Surgery (Pre-Certification may be required)</td>
</tr>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>Includes Ambulatory Surgi-Center Care, Outpatient cataract surgery, Chemotherapy, MRI, CT scan, and other diagnostic procedures, End Stage Renal Disease / Hemodialysis, Nuclear Medicine, Inhalation Therapy, Radiation Therapy, Sleep Apnea, Vasectomy</td>
</tr>
</tbody>
</table>

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Al GU RetireeSOB 142939

09/10/2019
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>PARTICIPATING</th>
<th>NON-PARTICIPATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Responsibility</td>
<td>In-Network Inside &amp; Outside of Guam</td>
<td>Out-of-Network Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-certification Penalty</td>
<td>No penalty</td>
<td>$400.</td>
</tr>
</tbody>
</table>

Pre-Certification for certain types of Non-Preferred care received inside the U.S. must be obtained to avoid a reduction in benefits paid for that care. Pre-Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required - excluded amount applied separately to each type of expense. Contact the service center to determine if pre-certification is needed for a procedure.

All Medicare eligible services must be pre-certified by Medicare.

| Emergency Room | 20% | 20% |
| Non-Emergency Use of the Emergency Room | 50% | 50% |
| Urgent Care | 20% | 20% |
| Non-Urgent Use of Urgent Care Provider | 50% | 50% |
| Ambulance Services | 20% | 20% |

| Physician Services |  |
| Physician Office Visit | No charge% | 20% |
| Specialist Office Visit | No charge% | 20% |

| Mental Health & Alcohol/Drug Abuse Services |  |
| Mental Health Inpatient Unlimited days per Plan Year | No charge% | 20% |
| Mental Health Outpatient Unlimited visits per Plan Year | No charge% | 20% |
| Substance Abuse Inpatient Unlimited days per Plan Year | No charge% | 20% |
| Substance Abuse Outpatient Unlimited visits per Plan Year | No charge% | 20% |

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### Plan Features

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>PARTICIPATING In-Network Inside &amp; Outside of Guam</th>
<th>NON-PARTICIPATING Out-of-Network Inside &amp; Outside of Guam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Child Physical Exams</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>7 exams in the first 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, and 1 exam per 12 months thereafter to age 22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Immunizations/vaccinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Adult Physical Exams</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Immunizations/vaccinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Gynecological Exams</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Includes 1 exam and pap smear per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes sterilization and tubal ligation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Mammograms</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prostate Specific Antigen (PSA)</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Digital Rectal Exam (DRE)</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Recommended: For all members age 50 and older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Hearing Exams</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Includes one routine exam every 24 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>$500 per member, per plan year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Member Responsibility</td>
<td>In-Network Inside &amp; Outside of Guam</td>
<td>Out-of-Network Inside &amp; Outside of Guam</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
<td></td>
</tr>
<tr>
<td>Acupuncture: 30 visits per member, per plan year</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Spinal Disorder Treatment: Unlimited visits per Plan Year</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Short Term Rehabilitation</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

(Includes coverage for Occupational, Physical and Speech Therapies; 60 combined visits per Plan Year)

| Diagnostic Outpatient X-ray                      | No charge%    | 20%               |
| Diagnostic Outpatient Lab                        | No charge%    | 20%               |
| Blood & Blood Derivatives                        | 20%           | 20%               |
| Base Infertility Services                        | 20%           | 20%               |
| (Base plan coverage includes coverage limited to the testing and treatment of underlying condition) |
| Durable Medical Equipment: Unlimited lifetime maximum Including Orthopedic conditions | 20%           | 20%               |
| Implants: Limitations apply                      | 20%           | 20%               |
| Allergy Testing: Unlimited                       | 20%           | 20%               |
| Allergy Serum & Injections: Does not include those on the Specialty Drugs List & Orthopedic injections | 20%           | 20%               |
| Organ Transplants: Unlimited lifetime maximum Includes Organ Donors Precertification Required | 20%           | 20%               |
| Aids Treatment: Precertification Required        | 20%           | 20%               |
| Diabetics Supplies:                               | 20%           | 20%               |
| Payment for Non-Preferred Providers*             | Not Applicable | Professional: 105% of Medicare Facility: 140% of Medicare |
| Airfare Benefit:                                 | No charge      | Not covered       |

For members who meet qualifying conditions, Plan provides roundtrip airfare (Plan Approval Required)

Autism: Autism covered same as any other expense. Member cost sharing is based on the type of service performed and the place of service where it is rendered.

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong></td>
<td><strong>In-Network Inside &amp; Outside of Guam</strong></td>
<td><strong>Out-of-Network Inside &amp; Outside of Guam</strong></td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic Drugs</strong></td>
<td>$15 copay per month supply (free for 90 day Mail Order Drugs)</td>
<td>20%</td>
</tr>
<tr>
<td>(365 day maximum supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Includes contraceptives</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Formulary Brand Name Drugs</strong></td>
<td>$30 copay per month supply (free for 90 day Mail Order Drugs)</td>
<td>20%</td>
</tr>
<tr>
<td>(365 day maximum supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Includes contraceptives</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non Formulary Generic and Brand Name Drugs</strong></td>
<td>$100 copay per month supply (free for 90 day Mail Order Drugs)</td>
<td>20%</td>
</tr>
<tr>
<td>(365 day maximum supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Includes contraceptives</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Drugs</strong></td>
<td>$100 copay per month supply</td>
<td>Not covered</td>
</tr>
<tr>
<td>(365 day maximum supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Eye Exams</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><em>(Covered under medical) Includes 1 exam every 12 months</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Care Supplies</strong></td>
<td>No charge up to $150 maximum</td>
<td>No charge up to $150 maximum</td>
</tr>
<tr>
<td><em>(Schedule maximums apply every 12 months)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
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Plan Features

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<tr>
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<th>Participating</th>
<th>Non-Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Employee Assistance Program (IEAP)</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>International Disease Management</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>International Maternity Management Program</td>
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</tr>
<tr>
<td>Simple Steps To A Healthier Life®</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Wellness Checkpoint</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.

The proposed plan of benefits is underwritten by Aetna Life Insurance Company. This is only a brief summary of the benefits available. Some restrictions may apply.

If you have Maryland or Washington membership, a separate policy may be required.

For more specific information about the coverage details, including limitations, exclusions and other plan requirements, please refer to the plan booklet (which will be provided near the time the plan becomes effective).

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Schedule of Benefits and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents. In the event of a discrepancy between the benefit grid and the Contract, between the Government of Guam and Aetna, the contract will prevail.

Al GU RetireeSOB 142939

10/01/2019
<table>
<thead>
<tr>
<th>Medical Plan Caveats</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Limits</strong></td>
</tr>
<tr>
<td>Payment limits apply per individual on a Plan Year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. Deductibles, copays, pre-certification penalty and 50% items are excluded from the payment limit.</td>
</tr>
<tr>
<td><strong>Plan Year and Per Confinement Deductibles</strong></td>
</tr>
<tr>
<td>There is no cross-application between Plan Year and per confinement deductibles. If a member is hospitalized, he or she must meet both per confinement and Plan Year deductibles (as applicable) before the plan pays any benefits.</td>
</tr>
<tr>
<td><strong>Coverage Maximum (Days/Visits)</strong></td>
</tr>
<tr>
<td>Coverage maximums up to a certain number of days/visits per Plan Year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).</td>
</tr>
<tr>
<td><strong>In-Network Deductible/Coinsurance</strong></td>
</tr>
<tr>
<td>In-Network - deductible and coinsurance may apply to pap smears, DRE tests and PSA tests if billed by an independent laboratory provider.</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
</tr>
<tr>
<td>Maternity expenses are covered as any other medical expense. Coverage is provided for enrollee or survivor and eligible dependents. Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.</td>
</tr>
<tr>
<td><strong>Ancillary Services</strong></td>
</tr>
<tr>
<td>For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.</td>
</tr>
<tr>
<td><strong>Pre-Existing Conditions</strong></td>
</tr>
<tr>
<td>No Restrictions</td>
</tr>
<tr>
<td>Pre-existing condition limitation is waived on the effective date. Pre-existing condition limitation is waived after the effective date.</td>
</tr>
<tr>
<td><strong>Payment for Non-Preferred Providers</strong></td>
</tr>
<tr>
<td>We cover the cost of care differently based on whether healthcare providers, such as doctors and hospitals, are &quot;in network&quot; or &quot;out of network.&quot; We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care. As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital. When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the &quot;recognized&quot; or &quot;allowed&quot; amount. When you choose out-of-network care, Aetna &quot;recognizes&quot; an amount based on what Medicare pays for these services. The Federal government sets the Medicare rate. Exactly how much Aetna &quot;recognizes&quot; depends on the plan you or your employer picks. Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan &quot;recognizes&quot; or &quot;allows.&quot; Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type &quot;how Aetna pays&quot; in the search box. You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to <a href="http://www.aetna.com">www.aetna.com</a> and click on &quot;Find a Doctor&quot; on the left side of the page. If you are already a member, sign in to your Aetna Navigator member site. This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.</td>
</tr>
</tbody>
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**Note:** This is not evidence of coverage, you must enroll and be accepted by the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Schedule of Benefits and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents. In the event of a discrepancy between the benefits grid and the Contract, between the Government of Guam and Aetna, the contract will prevail.