

BENEFIT PLAN

**Prepared Exclusively For
Adobe Inc.**

International Business Travel Plan

**World Traveler Plus Business Travel & Business
Sojourn**

**Aetna Life & Casualty (Bermuda) Ltd
Booklet**

This Booklet is part of the Group Insurance Policy between
Aetna Life & Casualty (Bermuda) Ltd. and the Policyholder

**What Your Plan
Covers and How
Benefits are Paid**





Emergency Medical Insurance

Prepared exclusively for:

Policyholder:	Adobe Inc.
Group policy number:	299440-10-039
Benefit Plan:	Booklet 9
Group policy effective date:	January 1, 2026
Plan effective date:	January 1, 2026
Plan issue date:	December 11, 2025

The benefits shown in this Plan are available for you solely while on a **Business Trip or Business Sojourn** authorized by your Employer.

Underwritten by Aetna Life & Casualty (Bermuda) Ltd.

Welcome

Thank you for choosing **Aetna**.

This is your booklet. It is one of three documents that together describe the benefits covered by your **Aetna** plan.

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

The third document is the **group policy** between **Aetna Life Insurance Company** (“**Aetna**”) and the policyholder. Ask the policyholder if you have any questions about the **group policy**.

Oh, and each of these documents may have amendments attached to them. They change or add to the documents they’re part of.

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

Welcome to your **Aetna** plan.

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Schedule of benefits

Issued with your booklet

Let's get started!

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

Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

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

What your plan does – providing covered benefits

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

Health Expense Coverage

This plan covers expenses associated with **Urgent** and **Emergency Care** while on a Business Trip or Business Sojourn authorized by your employer. Please refer to the definition of these terms found in the Glossary section of this document. Benefits are payable for covered health care expenses that are incurred by you while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply. This plan provides coverage for the following:

See the *Eligible health services under your plan* section. for more information about your coverage.

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 your business trip ends Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us.

How your plan works while you are covered

Your coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.

1. Eligible health services

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

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

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

2. Providers

You can directly access doctors, **hospitals** and other health care **providers** for the care you need. You can find **providers** and see important information about them most easily on our online **provider directory**. Just log into your secure member website at www.aetnainternational.com.

3. Paying for eligible health services– the general requirements

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

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

You will find details on **medical necessity** requirements in the *Medical necessity and precertification requirements* section.

4. Disagreements

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. For more information see the *When you disagree - claim decisions and appeals procedures* section.

How your plan works while you are covered outside your home country

You have coverage outside your home coverage

Your outside of your home country coverage:

- Means you can get **eligible health services** outside your home country. See the *Eligible health services under your plan* section.

You will find details on:

- Reimbursement for care from **providers** outside your home country in the *General provisions – other things you should know* section
- Claim information in the *When you disagree - claim decisions and appeals procedures* section

If you have questions, comments or concerns about your coverage or benefits outside the U.S., you may contact us at: **Aetna Life Insurance Company**, Attn: Aetna International, 151 Farmington Avenue, Hartford, CT 06156

You may also use the toll free phone number on your paper ID card on your Member ID Card Flyer.

How to contact us for help

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

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

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your paper ID card on your Member ID Card Flyer

Your member ID card

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

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

You will have received your Member ID card flyer from your employer. Please be sure to keep a soft copy of the card handy when traveling internationally. If you haven't received it before you need **eligible health services**, or if you've lost it, check with your employer.

Who the plan covers

You will find information in this section about:

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

Who is eligible

You are in an Eligible Class if you are:

- A regular full-time employees including interns, part timers and employees under age 70 participating in this plan;
- traveling on a **Business Trip** or **Business Sojourn** for no more than 180 consecutive days for any one **Business Trip** or **Business Sojourn** with no more than 270 travel days in a 12 month period; and
- traveling outside your **Home Country**. If your country of residence and/or domicile is the United States or any U.S. Territory/Protectorate, travel between any combination of the 50 United States and U.S. territories/ protectorates is considered traveling within home country.

When you can join the plan

- Your coverage will take effect under this plan for a **Business Trip** or **Business Sojourn** if you are a full-time worker as determined by your Employer and shall begin when you leave your **Home Country** and ends when you return to your **Home Country**.

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

If your plan includes coverage for dependents, you can cover the following family members on your plan. (They are referred to in this booklet as 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
 - The children must be under 26 years of age, and they include:
 - Biological children
 - Stepchildren
 - Legally adopted children, including any children placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
 - Grandchildren in your court-ordered custody
 - Any other child with whom you have a parent-child relationship

Who can be your dependents

You can have the following dependents:

- A spouse - If you marry, you can put your spouse on your plan.
 - Ask the policyholder when benefits for your spouse will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
 - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
 - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on this emergency health plan for the first 31 days after birth.
 - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
 - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
 -

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for health benefits.

Eligible health services under your plan

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

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

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exception (exclusion).

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

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

Important note:

Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

Physicians and other health professionals

Physician services

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

- At the **physician's** office
- In a **hospital**
- From any other inpatient or outpatient facility

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

- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**

Anesthetics

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

Hospital and other facility care

Hospital care

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

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

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

Alternatives to hospital stays

Outpatient surgery and physician surgical services

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

Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**. **Urgent** and **Emergency care** expenses incurred for a serious **illness** or **injury** while on a **Business Trip** are covered.

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

In case of a medical emergency

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

Non-emergency condition

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

In case of an urgent condition

Urgent condition

If you need care for an **urgent condition**, you may access urgent care from an **urgent care facility**.

Non-urgent care

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

Specific therapies and tests

Other services

Ambulance service

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

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

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

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

What your plan doesn't cover – some eligible health service exceptions

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

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

- Under "General exceptions" we've explained what general services and supplies are not covered under this plan covering expenses associated with **Urgent** and **Emergency Care**.
- Below the general exceptions, in "Exceptions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

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

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

General exceptions

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

Examples of these are:

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

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

Cosmetic services and plastic surgery

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

Counseling

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

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you

- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care

Dental services related to:

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

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

Early intensive behavioral interventions

Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing.
- Special education, remedial education, wilderness treatment program, job training and job hardening programs

Examinations

Any health examinations needed:

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

Experimental or investigational

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

Extreme or action sports

- Mountaineering or rock climbing necessitating the use of guide ropes; potholing; ballooning; motor racing; speed contests; skydiving; hang gliding; parachuting; spelunking; heli-skiing; extreme skiing; bungee cord jumping; deep sea diving utilizing a hard helmet with air hose attachments; racing of any kind (other than on foot); and all professional sports

Facility charges

For care, services or supplies provided in:

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

Foot care

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

Growth/height care

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

Hearing exams

Jaw joint disorder

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

Maintenance care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages
 - Bedpans
 - Syringes
 - Blood or urine testing supplies
 - Other home test kits
 - Splints
 - Neck braces
 - Compresses
 - Other devices not intended for reuse by another patient

Other primary payer

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

Outpatient prescription or non-prescription drugs and medicines

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

Personal care, comfort or convenience items

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

Pregnancy charges

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

Routine exams

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

Services provided by a family member

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

Sexual dysfunction and enhancement

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

Spinal manipulation

- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body
- Other physical treatment of any condition caused by or related to neuromusculoskeletal disorders of the spine, including manipulation of the spine

Strength and performance

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

Telemedicine

- Services given when you are not present at the same time as the **provider**

Therapies and tests

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

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
 - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
 - Hypnosis and other therapies
 - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
 - Nicotine patches
 - Gum

Treatment in a federal, state, or governmental entity

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

Vision care

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

Wilderness treatment programs

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

Work related illness or injuries

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

Additional exceptions for specific types of care

Preventive care and wellness

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

Physicians and other health professionals

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

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

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

Home health care

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

Hospice care

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will

- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
 - Sitter or companion services for either you or other family members
 - Transportation
 - Maintenance of the house

Outpatient private duty nursing

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

Emergency services and urgent care

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

Specific conditions

Maternity and related newborn care

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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):
 - Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
 - Sexual deviations and disorders except for gender identity disorders
 - Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
 - Pathological gambling, kleptomania, pyromania
 - School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
 - Services provided in conjunction with school, vocation, work or recreational activities
 - Transportation

Obesity (bariatric) surgery

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

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

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

Treatment of infertility

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

Specific therapies and tests

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

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

Other services

Ambulance services

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

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

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

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements

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

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Who provides the care

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

Providers

When you need medical care, you can go to any **provider** to provide **eligible health services** to you.

You will have to pay for services at the time that they are provided. You will 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 health services** that you paid directly to a **provider**.

Important exceptions – when you pay all

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

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and precertification requirements* section.
- When, your **physician** requested it, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

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

Special financial responsibility

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

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 health services**.

When a claim comes in, we decide 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

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none">You should notify and request a claim form from us.The claim form will provide instructions on how to complete and where to send the form(s).	<ul style="list-style-type: none">You must send us notice and proof as soon as reasonably possible.If you are unable to complete a claim form, you may send us:<ul style="list-style-type: none">A description of servicesBill of chargesAny medical documentation you received from your provider
Proof of loss (claim)	<ul style="list-style-type: none">A completed claim form and any additional information required by us.	<ul style="list-style-type: none">You must send us notice and proof as soon as reasonably possible.
Benefit payment	<ul style="list-style-type: none">Written proof must be provided for all benefits.If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.	<ul style="list-style-type: none">Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** is 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 **provider** or to you as appropriate.

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

Urgent care claim

An urgent claim is one for which 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.

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

Post-service claim

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

Concurrent care claim extension

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

Concurrent care claim reduction or termination

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

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

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	8 business days for non-electronic (paper) precertification request 5 business days for electronic precertification request	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	48 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

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

Adverse benefit determinations

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

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

The difference between a complaint and an appeal

A complaint

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

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling the toll-free number on your ID card.

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 by calling the toll-free number on your ID card. 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 **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling the toll-free number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	15 days (level 1) 30 days (level 2)	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

In most situations you must complete the two levels of appeal with us before you can take these other actions regarding an alleged breach of the policy terms by Aetna Life & Casualty (Bermuda) Ltd.; or any matter within the scope of the Appeals Procedure:

- Contact your U.S. state's Department of Insurance to request an investigation of a complaint or **Appeal**; or
- File a complaint or **Appeal** with your state's Department of Insurance
- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

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

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

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.

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your business trip ends
- Your employment ends
- Your plan sponsor does not make any required contributions
- We end your coverage
- You become covered under another medical plan offered by your employer

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the 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.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above, other than:
 - Exhaustion of your overall maximum benefit
 - If you enroll under a group Medicare plan that we offer. However, dependent's coverage will end if your coverage ends under the Medicare plan
- Your dependent has exhausted the maximum benefit under your medical plan.

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide the policyholder a completed and signed 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 plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

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

We will not send you notice if your coverage is ending. Here is how the date is determined (other than the circumstances described in *Why would we end your coverage* above).

Your coverage will end on either the date you stop active work, or the day your business trip ends.

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet

We prepared this booklet according to 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 when we administer your coverage, so long as we use reasonable discretion.

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**.

Coverage and services

Your coverage can change

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

If a service cannot be provided to you

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

We will try hard to get you access to the services you need even if these things happen.

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

You or the 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. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

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

Some other money issues

Assignment of benefits

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

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

To request assignment you must complete an assignment form. The assignment form is available from the employer. The completed form must be sent to us for consent.

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 **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Recovery of overpayments

We sometimes pay too much for **eligible health 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 who the money comes from – for example, the other driver, the policyholder or another insurance company.

To help us get paid back, you are doing four things now:

- You are agreeing to repay us from money you receive because of your **injury**.
- You are giving us a 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.
- You are 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.
- You are 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 **providers'** claims and manage your plan

You can get a free copy of our Notice of Privacy Practices. Just call the toll-free number on your ID card.

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 prior coverage - transferred business

If your coverage under any part of this plan replaces any prior coverage, any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Outside the U.S. benefits

Reimbursement for providers outside of the United States

If, acting reasonably, we determine that any central bank or relevant government or governmental authority imposes an artificial exchange rate (including without limitation an exchange rate which is inconsistent with the free market exchange rate) in relation to a relevant currency for any reason, we may, in our sole discretion, reimburse you for your valid claims pursuant to this agreement for treatment in such country in any manner we may reasonably decide.

In making such determination, we shall seek to ensure that, in keeping with the fundamental basis of any contract of insurance, we indemnify you for your loss (subject to the terms and conditions of your policy) but do not unjustly enrich you as may have been the case had we applied such artificial exchange rate to pay you in another currency.

Providers In the United States

Payment will be issued in either:

- The applicable local currency (if feasible, at the sole discretion of **Aetna**).
- The currency in which the policy **premium** was paid, if you do not have a bank account in local currency. The amount will equal the applicable **recognized charge**.

Glossary

Aetna

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

Ambulance

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

Behavioral health provider

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

Birthing Center

A freestanding facility that meets **all** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
 - Complications arise during labor; or
 - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body mass index

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

Brand-name prescription drug

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

Business Sojourn

This means leisure travel in conjunction with business travel. The leisure travel can be directly before, during or after a **Business Trip**.

Business Trip

This means the period, which cannot be more than 180 consecutive days for any one trip, during which the covered person is traveling on business outside their **Home Country** and which is authorized by the Employer.

Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

Copay/copayments

The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary**.
2. You received **precertification** if required.

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if prescribed by a **physician** or given by trained medical personnel.

Deductible

The amount you pay for **eligible health services** per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means determined by a **physician** or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home

- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage

The date your and your dependents' coverage begins under this booklet as noted in **Aetna's** records.

Eligible health services

The health care services and supplies and **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *exceptions* section or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness** or **injury** is of a severe nature and that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency services

Treatment given in a **hospital's** emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet(s)
- The schedule of benefits
- Any amendments to the **group policy**, booklet, and schedule of benefits

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility for substance abuse**
- **Residential treatment facility for mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness

Poor health resulting from disease of the body or mind.

Injury

Physical damage done to a person or part of their body.

Intensive outpatient program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A myofascial pain dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

A pharmacy where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and **coinsurance**, to be paid by you or any covered dependents per Calendar Year for **eligible health services**.

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** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Pharmacy

An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Premium

The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

Prescriber

Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription

A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug

An FDA approved drug or biological which can only be dispensed by **prescription**.

Provider(s)

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

R.N.

A registered nurse.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include conditions you cannot attribute to a **mental disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Terminal illness

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

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

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.aetnainternational.com.

Emergency Assistance Services

Medical emergencies are unpredictable — but if they do happen, Aetna International is there for members and their families no matter where they are in the world. With our in-house Aetna Assistance team, we make sure you have access to necessary resources during a medical emergency 24 hours a day, seven days a week.

The following benefits, exclusions and requirements apply to you as the covered member along with any eligible dependents.

Aetna covered services and expenses – emergency services

- **Emergency or urgent medical evacuation:** Evacuation services may be necessary if you or your eligible dependent develops an emergency or urgent medical situation requiring immediate attention, and adequate medical facilities are not locally available. The plan will cover the cost of medically supervised evacuations to the closest facility capable of providing appropriate care.
- **Medical repatriation coordination:** Following an evacuation, the plan will cover the cost of a one-way economy fare to either your point of origin or to your permanent residence, or if appropriate, to a facility as defined by the plan if it is medically advisable once you are deemed in stable condition. This may include any medically supervised transportation or medical treatment administered en route.
- **Return of mortal remains:** We'll cover reasonable costs to transport your body or mortal remains to your home country or country of residence as directed by your next of kin or estate. In the event of a burial, we'll cover the cost of opening or reopening a grave, exclusive right of burial fee and burial costs. In the event of a cremation, we'll cover the cost of any doctor's certificates and cremation costs, including the removal of any medical devices before cremation.
- **Return of dependent children:** If a child is left unattended as a result of your accident or illness, we'll cover the cost of a one-way economy airfare to the child's permanent residence. Coverage for a qualified attendant will also be provided if required.
- **Companion travel coordination:** Following an evacuation, if you are alone and hospitalized for more than seven (7) days, we'll cover the cost of a round-trip economy airfare for one person chosen by you to travel to and from the place of hospitalization.

All evacuations, returns to residence after stabilization and/or repatriations of mortal remains are coordinated by and subject to prior approval of Aetna International.

Aetna covered services and expenses – travel expenses

We will cover travel expenses incurred after your evacuation and/or release from the hospital due to illness or injury until you are fit to fly and return to your point of origin.

For the duration of your evacuation and period of admission, we'll cover:

- **Overnight accommodation costs** up to \$125 a night, if deemed necessary
- **The fare for a taxi** to take you from your accommodations to the hospital and back once a day

For any covered members or dependents under the age of 18, we'll pay the following costs for a parent or legal guardian:

- **Hospital accommodations** to stay with the child if receiving inpatient treatment
- **Reasonable accommodation costs at a hotel** (up to \$125 a night) for them to stay with the child if they can't return to their country of residence and the child's accommodation costs are covered in this section

Aetna covered services and expenses – medical assistance services

Our Care and Response Excellence (CARE) team of clinicians can provide assistance by email or phone with:

- **Pre-trip planning** — Updated information on required vaccinations, health risks, and travel restrictions for worldwide destinations
- **Medical referrals** — Referrals to the most appropriate, nearby medical care resources, including preferred access to our network of medical providers

The benefits listed above are subject to overall evacuation dollar maximum limitations.

Definitions, requirements and exclusions

Definitions

- **Accident** — A sudden, violent, external, unforeseen and identifiable event
- **Emergency** — A situation that, in the professional opinion of your physician, poses a clear and significant risk of death or imminent serious injury or harm to you or your eligible dependents
- **Home country** — The country where you primarily reside and will return to when repatriated, or a country where you hold a valid passport
- **Host country** — The country you are visiting
- **Member** — Any eligible person who has enrolled in Aetna Assistance through a participating plan sponsor
- **Personal belongings** — Any items you take on, or acquire during, an insured journey that are your personal property or are property you're personally responsible for
- **Qualified medical practitioner** — A doctor or specialist who is registered or licensed to practice medicine under the laws of the country they practice in; excludes you, your partner, any members of your immediate family or any of your employees

Requirements

Contact and claims requirements

- You or someone on your behalf must contact us as soon as possible to confirm eligibility for covered expenses. Failure to do so may invalidate your eligibility for payment of transportation and other expenses.
- The evacuation method and destination chosen must meet Aetna Assistance requirements. Failure to do so may invalidate payment of subsequent transportation expenses.
- All assistance service-related bills incurred by you or your eligible dependents must be submitted to us for payment consideration.

Exclusions

General exclusions

Some of the costs you may incur during your period of convalescence from a medical emergency are not covered by this plan. These include:

- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Telephone calls
- Ground transportation beyond the specific covered benefits outlined in this document

Travel assistance services exclusions

We may be able to help with travel issues and coordination when appropriate. You are responsible to pay any costs associated with the following services if they are incurred:

- 24/7 emergency travel assistance
- Translation and interpreter services
- Emergency cash advance assistance
- Replacement of lost travel documents assistance
- Legal referrals

Claims exclusions

We will not be responsible for the cost of services or expenses arising from the following situations involving you or your eligible dependents:

- Abuse of drugs or alcohol

- Military or police service operations
- Successful or attempted commission of an unlawful act
- Aviation, except where you or your eligible dependents fly as a passenger in an aircraft properly licensed to carry passengers (except the Military Aircraft Command of the United States or similar air transport service of other countries)
- Travelling against a physician's advice
- Travelling for the purpose of obtaining medical treatment
- Non-emergency expenses for routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious injury or harm to you or your eligible dependents
- Loss due to Customs or any other authority legally taking or destroying your property
- A condition not requiring emergency evacuation that would allow for treatment at a future date convenient to you or your eligible dependents
- Mountaineering or rock climbing necessitating the use of guide ropes; potholing; ballooning; motor racing; speed contests; skydiving; hang gliding; parachuting; spelunking; heli-skiing; extreme skiing; bungee cord jumping; deep sea diving utilising a hard helmet with air hose attachments; racing of any kind (other than on foot); and all professional sports

Accessing your emergency benefits

At Aetna International, we are here for you 24/7 — for medical emergencies, non-emergency needs and everything in between. Our member service representatives work closely with Aetna Assistance representatives whenever urgent or emergency situations arise.

In cases of immediate emergency

1. Go immediately to the closest physician or hospital.
2. Once it's possible, call us (or have someone on your behalf call us) using the emergency number shown on the back of your Paper Aetna International Member ID card.

While we will do everything reasonably possible to direct you or your eligible dependents to the most appropriate care available once we receive a call, we are not responsible for the availability, quantity, quality or result of any medical treatment you may receive or your failure to obtain medical treatment.

In cases where you are able to call

Call us using the emergency number on the back of your Member ID card if you or your eligible dependents:

- Have an urgent medical concern or question
- Are hospitalized or are about to be hospitalized

- Are involved in an accident requiring medical treatment
- Are having difficulty locating urgent medical care
- Require a referral for translation services in order to receive urgent medical care

Information to provide when you call

When you or your eligible dependents call us in emergency situations, you will need to provide:

- Your policy name
- Your Member ID number (found on your Member ID card flyer)
- Your name or the name of your eligible dependent in need of emergency assistance
- Your identification number affiliated with the group providing this coverage
- The name of the person calling on your behalf if applicable
- The nature of the illness, injury, medical problem or emergency and the type of help needed

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Plans and programs are underwritten or administered by Aetna Life & Casualty (Bermuda) Ltd. or Aetna Life Insurance Company (Aetna).

Aetna does not provide care or guarantee access to health services. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.AetnaInternational.com. Whenever coverage provided by any insurance policy is in violation of any U.S, U.N or EU economic or trade sanctions, such coverage shall be null and void. For example, Aetna companies cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions.

Aetna does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to aetnainternational.com