



Aetna Retiree 80/20 Addendum

The information below is intended to serve as an update to the 2010 Aetna Retiree 80/20 Plan Summary Plan Description (SPD).

Effective January 1, 2018

The Aetna Retiree 80/20 Plan did not have any plan design changes.

Effective January 1, 2017

- Aetna's Retiree Service Center handles the administration for billing, enrollment, and coverage changes.
- The Retiree 80/20 Plan coverage starts the first day of the month following your retirement date unless your retirement date is the first day of the month, then it is effective that date. Employees covered in an endowed health plan prior to retirement will be automatically enrolled. If an employee is not enrolled prior to retirement, they have a one-time opportunity to enroll and must do so within 90 days of their retirement date.
- The individual deductible of \$550 applies to each person separately; the individual out-of-pocket maximum of \$3,550 applies to each person separately.
- Individuals on Long-Term Disability and Medicare eligible, are covered on the Retiree 80/20 Plan
- Retirees who return to a benefits eligible position are required to enroll in an active employer health plan. They are not able to remain on Aetna's Platform for coverage for themselves and eligible family members.
- The routine physical exam benefit has been extended to include the spouse/domestic partner, Medicare eligible dependents.
- Hearing Aids are no longer be subject to a deductible
- Enrollment Changes-Updates to Page 6. Retirees have 31 days to contact Aetna's Retiree Service Center to make enrollment changes if they experienced a Life Event (i.e. marriage)
- Updates to the Continuing Coverage Section:
 - Spouse, Domestic Partner and Dependent Coverage After Your Death. In the event that an active employee covered under an active endowed health plan dies, eligible dependents covered at the time of the active employee's death will continue coverage under the RPHP Plan if non-Medicare eligible, if Medicare eligible, offered the Retiree 80/20 Plan or MAPD. If a retiree dies, covered under the RPHP Plan, the surviving spouse, domestic partner, and any current or future eligible covered dependent children may continue the health plan until the surviving spouse remarries or the domestic partner enters a new domestic partnership, and/or

the dependent children no longer qualify under the program's definitions. Coverage is effective the first of the month following the date of death. If the date of death is the first day of the month, then the coverage is effective as of that day.

- Divorce or Legal Separation. If you and your spouse decide to divorce or you and your domestic partner decide to terminate the domestic partnership, you (and any eligible dependents) can continue coverage. However, your ex-spouse/domestic partner will no longer be eligible to continue coverage under your plan but may be eligible to enroll in COBRA continuation coverage administered by PayFlex. You will need to call Aetna's Retiree Service Center at 1-800-338-4533 within 31 days of the divorce or termination of the domestic partnership, to notify Aetna of the divorce/termination of domestic partnership and remove the dependent from coverage. In addition, you will need to include a copy of the divorce decree (front and back page only) as proof. Domestic Partners are required to complete a Termination of Domestic Partnership form. Based on your notification to Aetna's Retiree Service Center, Aetna will notify PayFlex of the event and PayFlex will send a COBRA Election Packet.

If you and your spouse decide to legally separate, you can continue coverage for you, your legally separated spouse and any eligible dependents, or you can choose to cancel coverage for your legally separated spouse. If you do, they may be eligible to enroll in COBRA continuation coverage administered by PayFlex. You will need to call Aetna's Retiree Service Center at 1-800-338-4533 within 31 days of the legal separation to complete an enrollment form and remove the dependent from coverage. In addition, you will need to include a copy of the separation agreement (front and back page only) as proof. Based on your notification to Aetna, Aetna will notify PayFlex and they will send COBRA Election Packet.

Effective January 1, 2016

The Prescription Drug Plan is changing from Express Scripts (ESI) to OptumRx

- The copays are not changing and remain \$5/\$30/\$50 for retail and \$10/\$60/\$90 Home Delivery in-network
- The drug formulary is changing
- Some medications are excluded
- Home Delivery of maintenance medications/specialty medications can be delivered to your home address or new for 2016, you can direct the delivery to Gannett Health Center Pharmacy on the Ithaca campus.
- Briova is the specialty pharmacy replacing ESI's Accredo
- Aspirin products, iron supplements, Vitamin D, Folic Acid & Prenatal Vitamins with prescription covered at \$0 copay (in-network) according to regs. under ACA.

Effective April 1, 2015

Documentation Requirements Effective 4/1/15 & updated 1/1/16-copies only

- Spouse or Domestic Partner: Marriage Certificate, Domestic Partner Statement

- **Children (biological), stepchild, adopted:** Birth Certificate (or Visa/Passport accepted for non-US citizens), Proof of Disability, if applicable, Documentation establishing Paternity by Court Order acknowledging Paternity. If your child is neither of the above, you must also complete the Special Dependent Enrollment Form.

Effective January 1, 2015

Express Scripts Prescription Drug Plan Changes

- **Preferred Retail Pharmacy Network:** You pay \$5/\$30/\$50 copay at retail for up to a 30 day supply if you use pharmacies participating in the Preferred Retail Pharmacy Network. Pharmacies include: Kinney, Rite Aid, Target, Walmart, Wegmans, Quilans, Green Street Pharmacy, Gannett Student Health Center. You pay \$15/\$40/\$60, if you use CVS/Walgreens (Duane Reed), pharmacies not participating.
- **Exclusionary Formulary:** Certain medications that are available as generics or on the formulary are no longer covered as of 1/1/15. Members can appeal and ESI will review the clinical information provided by the physician.

Certificates of Creditable Coverage (HIPAA Certs) No Longer Required

The Affordable Care Act prohibits the use of pre-existing condition clauses resulting in the need to provide certificates of creditable coverage no longer necessary. On February 24, 2014, the Treasury, the Department of Labor, and the Department of Health and Human Service jointly issued final regulations which eliminated the requirement for plan sponsors to issue the certificates after 12/31/14.

Effective August 29, 2013

On August, 29, 2013, the Internal Revenue released new federal tax guidelines for same-sex spouses. This is due to the Supreme Court's ruling in United States v. Windsor that the Defense of Marriage Act (DOMA) provision prohibiting the recognition of same-sex marriages for federal law purposes was unconstitutional. The IRS determined that same-sex couples, legally married in jurisdictions that recognize their marriages, will be treated as married for federal tax purposes regardless of whether the couple lives in a jurisdiction that recognizes same-sex marriage. This means that if a same-sex couple is married in a state that recognizes same-sex marriage and moves to a state that does not recognize same-sex marriage, then he or she will still be considered married for federal tax purposes.

Autism Spectrum Disorder

Autism and other pervasive developmental disorders will now be covered the same as any other expense based on the type and place of service. Coverage will include applied behavioral analysis (ABA) and behavioral therapy as well as mental health therapy and testing services.

PLAN FEATURES	BENEFIT
Individual Deductible	\$550
Family Deductible	\$1,100

PLAN FEATURES	BENEFIT
Physician Services	
Office Visits	80% per visit after Calendar Year deductible
Outpatient Treatment of Mental Disorders	
Outpatient Services	80% per visit after Calendar Year deductible
Short Term Outpatient Rehabilitation Therapies	
Outpatient Physical, Occupational and Speech Therapy	80% per visit after Calendar Year deductible
Maximum Visit Limit per Calendar Year for Speech Therapy Only	50 visits

Generally it includes the following primary services:

- Evaluation and treatment by a speech-language pathologist
- Audiological hearing evaluation
- Medical evaluation
- Behavior modification
- Intensive education interventions
- Medical therapy or psychotherapy

You must call to Precertify psychological testing, neuropsychological testing and applied behavioral analysis.

Not all services are covered.

Aetna considers the following procedures and services experimental and investigational because the peer-reviewed medical literature does not support the use of these procedures and services in the assessment and treatment of autism and other pervasive developmental disorders:

Assessment:

1. Allergy testing (including food allergy for gluten, casein, candida, and other molds; allergen specific IgG and IgE)
2. Electronystagmography (in the absence of dizziness, vertigo, or balance disorder)
3. Erythrocyte glutathione peroxidase studies
4. Event-related brain potentials
5. Hair analysis for trace elements (see [CPB 0300 - Hair Analysis](#))
6. Intestinal permeability studies
7. Magnetoencephalography/magnetic source imaging (see [CPB 0279 - Magnetic Source](#))

[Imaging/Magnetoencephalography](#))

8. Neuroimaging studies such as CT, functional MRI (fMRI), MRI, MRS (see [CPB 0202 - Magnetic Resonance Spectroscopy \(MRS\)](#)), PET (see [CPB 0071 - Positron Emission Tomography \(PET\)](#)), and SPECT (see [CPB 0376 - Single Photon Emission Computed Tomography \(SPECT\)](#))
9. Nutritional testing (e.g., testing for arabinose and tartaric acid)
10. Provocative chelation tests for mercury
11. Stool analysis
12. Tests for celiac antibodies
13. Tests for homocysteine (see [CPB 0763 - Homocysteine Testing](#))
14. Tests for immunologic or neurochemical abnormalities
15. Tests for micronutrients such as vitamin levels
16. Tests for mitochondrial disorders including lactate and pyruvate
17. Tests for thyroid function
18. Tests for urinary peptides
19. Tests for amino acids (except quantitative plasma amino acid assays to detect phenylketonuria), fatty acids (non-esterified), organic acids, citrate, silica, urine vanillylmandelic acid
20. Tests for heavy metals (e.g., antimony, arsenic, barium, beryllium, bismuth, mercury)
21. Tests for trace metals (e.g., aluminum, cadmium, chromium, copper, iron, lead, lithium, magnesium, manganese, nickel, selenium, zinc)
22. Tympanometry (in the absence of hearing loss).

Treatment

1. Acupuncture
2. Anti-fungal medications (e.g., fluconazole, ketoconazole, metronidazole, nystatin)
3. Anti-viral medications (e.g., acyclovir, amantadine, famciclovir, isoprinosine, oseltamivir, valacyclovir)
4. Auditory integration training (auditory integration therapy) (see [CPB 0256 - Sensory and Auditory Integration Therapy](#))
5. Chelation Therapy (see [CPB 0234 - Chelation Therapy](#))
6. Cognitive rehabilitation (see [CPB 0214 - Cognitive Rehabilitation](#))
7. Elimination diets (e.g., gluten and milk elimination)
8. Facilitated communication
9. Herbal remedies (e.g., astragalus, berberis, echinacea, garlic, plant tannins, uva ursi)
10. Floor time therapy
11. Holding therapy
12. Immune globulin infusion
13. Manipulative therapies
14. Massage therapy
15. Music therapy and rhythmic entrainment interventions
16. Neurofeedback/EEG biofeedback (see [CPB 0132 - Biofeedback](#))
17. Nutritional supplements (e.g., dimethylglycine, glutathione, magnesium, megavitamins, omega-3 fatty acids, and high-dose pyridoxine)
18. Secretin infusion
19. Sensory integration therapy (see [CPB 0256 - Sensory and Auditory Integration Therapy](#))
20. Stem cell transplantation
21. Systemic hyperbaric oxygen therapy (see [CPB 0172 - Hyperbaric Oxygen Therapy \(HBOT\)](#))
22. Tomatis sound therapy
23. Vision therapy (see [CPB 0489 - Vision Therapy](#))

- 24. Vitamins and minerals (calcium, germanium, magnesium, manganese, selenium, tin, tungsten, vanadium, zinc, etc.).
- 25. Weighted blankets/vests.

Please refer to Aetna’s Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: http://www.aetna.com/cpb/medical/data/600_699/0648.html.

Transgender Health

Transgender, transsexual and gender nonconforming disorders will now be covered the same as any other expense based on the type and place of service. Coverage will include therapy and certain medical procedures related to gender identity confirmation procedures.

Generally it includes the following primary services:

- Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.
- Medically necessary core surgical procedures for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic and not covered. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic and not covered. Please refer to Aetna’s Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: http://www.aetna.com/cpb/medical/data/600_699/0615.html.

PLAN FEATURES	BENEFIT
Individual Deductible	\$550
Family Deductible	\$1,100
PLAN FEATURES	
<i>Physician Services</i>	
<i>Office Visits</i>	80% per visit after Calendar Year deductible
<i>Outpatient Treatment of Mental Disorders</i>	
<i>Outpatient Services</i>	80% per visit after Calendar Year deductible
<i>Short Term Outpatient Rehabilitation Therapies</i>	
<i>Outpatient Physical, Occupational and Speech Therapy</i>	80% per visit after Calendar Year deductible
Maximum Visit Limit per Calendar Year	50 visits

for Speech Therapy Only	
Surgery	
Performed in a Physician's Office	80% per visit/surgical procedure after Calendar Year deductible
Performed in a Hospital	80% per visit/surgical procedure after Calendar Year deductible

You can find a participating provider through Aetna's DocFind Site:

- <http://www.aetna.com/docfind>
- Select Directories and Resources on the left hand side of the page
- Click on GLTB provider resources
- From there, a disclaimer will pop up saying you are leaving the Aetna site and redirected to the GLTB site where you can go to "Resources" on the top of the page, then select "For Patients" and "Find a provider". If you encounter any problems accessing the site from DocFind, you can get there directly via www.glma.org.
- Once you have selected the applicable provider, you will need to return to the Aetna DocFind to confirm if they are a participating provider in Aetna's network.

You can also call Aetna's Member Services at 877-371-2007, if you need assistance.

Effect of Medicare

Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

Clarification for 1/1/13: This will also be done and regardless if the provider accepts Medicare assignment, if the provider does not accept Medicare assignment or if the provider opts-out of Medicare.

Business Travel Abroad Coverage

Faculty and staff travelling abroad on university business can access help for medical attention through Aetna International, a unit that specializes in corporate travel. This is a rider to the Endowed Health Plans that uses an established network of local medical providers in over 160 countries, pays for care in local currency and virtually eliminates the need to pre-pay bills and seek reimbursement upon returning to the USA. Aetna International is fully insured rider which does not allow coverage for individuals age 70 and older, which is a concern for an academic institution. However, the Aetna Retiree 80/20 plan continues to accept the liability for medically necessary treatment regardless of where that care is delivered and regardless of age.

For more information, please refer to our website

https://www.hr.cornell.edu/benefits/health/new_coverage.html#international

Plan Changes Effective 1/1/2013

Express Scripts/Medco Prescription Drug Plan

The Retail Refill Allowance (RRA) provision of the ES/Medco Prescription Drug Plan is eliminated.

Plan Changes Effective 1/1/2012

Same-Sex Partner coverage is changing to Domestic Partner coverage to include unmarried opposite sex partners. A Domestic Partnership Statement must be completed. Please refer to <http://hr.cornell.edu/benefits/partners.html> for more information.

Spouses of the same-sex married in New York State as well as the following jurisdictions: Connecticut, Iowa, Mass., New Hampshire, Vermont, Washington, DC and countries: The Netherlands, Belgium, Spain, Canada, South Africa, Norway, Sweden, Portugal, Iceland and Argentina, need only to provide a valid and current marriage certificate in order to enroll their spouse for health benefits. Please refer to <http://hr.cornell.edu/benefits/partners.html> for more information.

Medco Prescription Drug Copays Increasing Except Generics

Retail copays changing from \$5/\$25/\$45 to \$5/\$30/\$50

Mail Order copays changing from \$10/\$50/\$75 to \$10/\$60/\$90

Plan Changes Effective 1/1/2011

Medco Retail Refill Allowance

If a member continues to use the retail pharmacy instead of Medco By Mail to purchase maintenance medications, the member will pay a higher copay on the 4th refill for up to a 30 day supply. The copay will be \$5/\$40/\$65 (no change for generics) at retail instead of \$5/25/\$45.

Deductible

Individual in-network deductible is increasing from \$500 to \$550

Family in-network deductible is increasing from \$1,000 to \$1,100

Out of Pocket Maximum

Individual in-network out of pocket maximum is increasing from \$3,500 to \$3,550

Family out of pocket maximum is increasing from \$7,000 to \$7,100

Mental Health Treatment

The Plan covers medically necessary counseling services provided by a qualified provider while you are participating in a Wilderness Program provided you submit an itemized bill outlining the counseling services provided by a qualified mental health provider. A Wilderness Program does not otherwise meet the Plan's requirements to be considered a residential treatment facility, therefore, room and board and other supplies provided during a stay are not covered. This information revises the information on Page 36 of the Booklet.

Aetna Claims, Appeals and External Review

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to “you” in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims

An “Urgent Care Claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna’s claim decision no later than 15 days after the end of that additional period (or after receipt of the

information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this booklet). Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

“External Review” is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- (i) Your medical records;
- (ii) The attending health care professional's recommendation;
- (iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- (iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of

- the Plan, unless the terms are inconsistent with applicable law;
- (v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

- (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize
- (b) your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- (c) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.