# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

**Policyholder**: Walmart

**Group policy number**: GP-0895530
**Group control number:** CN-0486824

**Amendment effective date:** January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

**Important note**: The following apply only if you live in New Hampshire. The benefits below will apply instead of those in your booklet-certificate.

### Hospital care for dental procedures

**Eligible health services** include coverage for the **medically necessary hospital** or surgical day care facility charges and the administration of general anesthesia by a licensed anesthesiologist or anesthetist for dental procedures performed on a covered person who:

(a) Is a child under the age of 6 who is determined by a licensed **dentist** in conjunction with a licensed **physician** to have a dental condition which requires certain dental procedures to be performed in a surgical day care facility or **hospital** setting; or
(b) Is a person who has medical circumstances or a developmental disability as determined by a licensed **physician** which places the person at serious risk.

### Diabetic equipment, supplies and education

**Eligible health services** include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Diabetic needles and syringes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps

- Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

## Early intervention services

**Covered services** include services provided to your covered dependent child from birth to 3 years of age, who has an identified developmental disability. **Covered services** are those provided by:

- A speech-language pathologist
- An occupational and physical therapist
- A clinical social worker

The limit per 3 year period is $3,200 per child per year. Not to exceed $9,600 by the child's third birthday.

## Hearing aids and exams

**Eligible health services** include hearing care that includes hearing exams, the cost of a prescribed hearing aid for each ear and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

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

The maximum is $1,500 per hearing aid per ear every 60 months.

## Infertility services

### Basic infertility

**Covered services** include seeing a **provider**:

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

## Comprehensive infertility services

**Covered services** include the following **infertility** services provided by a **network infertility specialist**:

- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination
- Oral and injectable **prescription** drugs used:
  - To stimulate the ovaries
  - Primarily for treating the underlying cause of **infertility**

A "cycle" is defined as:

- An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination
- An artificial insemination cycle with or without injectable medication to stimulate the ovaries

You are eligible for these **covered services** if:

- You or your partner have been diagnosed with **infertility**
- You have met the requirement for the number of months trying to conceive through egg and sperm contact

## Aetna's National Infertility Unit

The first step to using your comprehensive **infertility covered services** is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits. They can also help your **provider** with **precertification.** You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

## Advanced reproductive technology (ART)

Advanced reproductive technology (ART)**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by a **network** ART **specialist**:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Sperm, egg and/or inseminated egg procurement and processing, or banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
- Cryopreservation (freezing) of eggs, sperm, and embryos when being done for medically necessary fertility preservation
- Assisted hatching
- Storage of eggs, sperm and embryos when done for medically necessary fertility preservation
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

- Oral and injectable **prescription** drugs used:
  - To stimulate the ovaries
  - Primarily for treating the underlying cause of **infertility**

An ART "cycle" is defined as:

| Procedure | Cycle count |
|---|---|
| One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo) | One full cycle |
| One fresh IVF cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo | One-half cycle |
| Fertilization of egg and transfer of embryo | One-half cycle |
| One cryopreserved (frozen) embryo transfer | One-half cycle |
| One complete GIFT cycle | One full cycle |
| One complete ZIFT cycle | One full cycle |

You are eligible for ART services if:

- You or your partner have been diagnosed with **infertility**
- You have exhausted comprehensive **infertility** services benefits or have a clinical need to move on to ART procedures

### Aetna's National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits and **precertification**. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

### Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

**Covered services** for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles

**How you can extend coverage for fertility preservation storage fees**

You have the right to extend coverage for storage of eggs, sperm and embryos when done for **medically necessary** fertility preservation when the policyholder asks to end coverage with us.

You will be responsible to pay the premium for this additional coverage. Eligible members will receive notification via US mail with additional information.

### Premature ovarian insufficiency

If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

The following are not **covered services**:

- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

## Maternity and related newborn care

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

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**.

Coverage also includes services provided by a certified midwife in a licensed health care facility or at home. Benefits are paid the same as any other **illness**.

## Nutritional support

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

**Covered services** include non-prescription enteral formulas for home use, as ordered by a **physician** stating the enteral formula is needed to sustain life and is **medically necessary**. Coverage is provided for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract. **Covered services** also include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not **covered services**:

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

## Obesity surgery

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

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

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

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

**Eligible health services** may also include, but may not be limited to:

- Before surgery psychological screening and counseling
- Behavior modification
- Weight loss
- Exercise routines
- Nutritional counseling
- After surgery follow-up, overview and counseling of dietary, exercise and lifestyle changes

**Eligible health services** are paid the same as any other **illness**.

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

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

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

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

- Accidental **injuries** and other trauma. Oral surgery and related dental services to return sound natural teeth and gums to their pre-trauma functional state. These services must be authorized or take place no

later than 24 months after the **injury**. Treatment needed because of **injury** to the jaw and mouth other than teeth shall be covered without time limit. All other requirements and exceptions of the booklet-certificate apply.

## Emergency prescriptions

**Eligible health services** include coverage for emergency **prescriptions**. This means a **pharmacist** may dispense a one-time emergency **prescription**, up to a 72-hour supply, of covered **prescription drugs** that are listed on your plan's formulary list. If prior authorization can't be obtained and is required to fill the **prescription**, coverage will be provided if a **pharmacist** has determined that either of the following is true

- The medication is needed to keep you alive or to continue therapy in a chronic condition
- Not having the **prescription** may produce unwanted health effects or may cause physical or mental discomfort

Exceptions to the above:

- The following drugs or classes of drugs or their medical uses, may be excluded from coverage or otherwise restricted when used:
  - For anorexia, weight loss, or weight gain
  - To promote fertility
  - For cosmetic purposes or hair growth
  - For the symptomatic relief of cough and colds
  - To promote smoking cessation

  Or when the drugs or class of drugs is:
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
  - Nonprescription drugs, except, in the case of pregnant women when recommended by or under the supervision of a physician, agents approved by the FDA for tobacco cessation
  - Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer
  - Barbiturates
  - Benzodiazepines
  - Agents when used for the treatment of sexual or erectile dysfunction, unless the agents have been approved by the FDA to treat a condition other than sexual or erectile dysfunction

## Prescription drugs

Under New Hampshire law, the following exception applies:
You may purchase up to a 90 day supply of covered **prescription** drugs at one time provided that:

- The **prescription** drug is on the **drug guide**
- You have taken the drug for a continuous period of one year
- The **prescription** drug is not subject to any **precertification** requirements

## Pharmacy medical exceptions

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **preferred drug guide,** for **brand-name, specialty prescription drugs,** or for which health care services are denied through **precertification** or **step therapy.** We maintain a quick exceptions process that will not exceed 48 hours. If approved, you may get coverage for a **medically necessary** non-formulary **prescription drug**.

You may also seek a medical exception for off-label drugs. We will quickly grant an exception for an off-label drug when your prescriber can prove that the other drug:

- has not worked in the treatment of your medical condition in the past
- is expected to not work based on your known features of the drug schedule
- will cause or will likely cause a bad reaction or other physical harm to you

- is not in your best interest, based on medical need, consistent with existing law

## Female contraceptives

**Eligible health services** include family planning services such as:

**Counseling services**

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

**Devices**

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

**Voluntary sterilization**

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

## Routine cancer screenings

**Eligible health services** also include the following routine cancer screenings:

- Mammograms:
  - At least one baseline mammogram for covered women at least age 35, but less than age 40.
  - At least one baseline mammogram every 2 years for covered women at least age 40, but less than age 50.
  - At least one mammogram per year for covered women age 50 and older.

## Prosthetic devices

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

**Eligible health services** also include scalp hair prosthesis worn for hair loss as a result of:

- Alopecia areata
- Alopecia medicamentosa
- Alopecia totalis

resulting from the treatment from any form of cancer or permanent loss of scalp hair due to **injury**. The **physician** treating you must certify that the prosthesis is **medically necessary**.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.
- Scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, alopecia medicamentosa and alopecia totalis resulting from the treatment from any form of cancer or permanent loss of scalp hair due to injury. Your treating physician must certify that the prosthesis is medically necessary.

Coverage includes:

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

The following has been added to or replaced in the *Coverage and exclusions* section of your booklet-certificate.

## Telemedicine

**Covered services** include **telemedicine** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license.

**Covered services** for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.aetna.com/ to review our **telemedicine provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

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

## Precertification

Failure to **precertify** your **eligible health services** when required will never result in a benefits reduction greater than $1,000.

## Coordination of benefits

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

## Key terms

Here are some key terms. These terms will help you understand *COB*.

Allowable expense means:

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

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

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

## Dependent children

You can also enroll the following family members on your plan.

- Your dependent children – your own or those of your spouse
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Those who are related to you by blood or law
    - Your legally adopted children

- Your foster children, including any children placed with you for adoption
- Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)
- Your grandchildren in your court-ordered custody
- Any other child with whom you have a parent-child relationship

## How can you extend coverage for your disabled child beyond the plan age limits?

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

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

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

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

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

Coverage will end on the earliest of the date:

- Your dependent is no longer handicapped
- Your child is no longer financially dependent upon you or your estate
- Contributions or premium is no longer paid for your child's coverage
- Dependent coverage ends for any reason other than reaching the maximum age under your plan

If:

- this plan replaces health coverage under another health plan and that plan covered handicapped dependent children;
- then any child covered under the previous plan will be eligible for coverage under this plan.

Any child whose coverage is continued under this section may be eligible to buy an individual plan through the Health Insurance Marketplace if they are no longer handicapped. For more information about the Marketplace, visit www.HealthCare.gov.

## Continuation of coverage for your dependents after your death

If you die while covered under any part of this plan, any health expense active coverage for your dependents may continue.

Your dependents must ask in writing to continue coverage. The request must be made within 45 days of when we notify your dependents of the right to continue or the date coverage would otherwise end. The request must include an agreement to pay up to 102% of the cost to this plan. Premium payments must continue.

Any dependent's coverage will not continue beyond the earliest of:

- The end of a 36 month period which starts on the date of your death; unless the coverage ends during such 36 month period for employees of the eligible class that you were in, coverage will be continued, unless terminated for another reason, until the later of:
  - 39 weeks from the date of such discontinuance

- the remainder of the 36 month period on the date of such discontinuance
- The date the dependent becomes eligible for the same or similar group benefits
- The end of the period for which any required contributions have not been made

Coverage may also be provided under this plan for your child, born after your death, as long as coverage for your other dependents continues.

If any coverage being continued ends because coverage has continued for the maximum period, your dependents may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov.

## Continuation of coverage for your child

If coverage for your child ends because the child no longer meets this plan's definition of dependent, your child may continue the active coverage.

A request in writing must be made within 45 days of when we notify the child of the right to continue and the date coverage ends. The request must include an agreement to pay up to 102% of the cost to this plan. Premium payments must continue.

Coverage will not continue beyond the earliest of:

- The end of a 36 month period which starts on the date the child no longer meets this plan's definition of dependent; unless the coverage involved ends during such 36 month period for employees of the eligible class that you are a member of, coverage will be continued, unless it ends for another reason, until the later of:
  - 39 weeks from the date of such discontinuance
  - the remainder of the 36 month period on the date of such discontinuance

- The date the child becomes eligible for same or similar group benefits
- The end of the period for which any required contributions have not been made

If any coverage being continued ends because coverage has been continued for the maximum period, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov.

## Continuation of coverage for your dependents after you become eligible for Medicare

If coverage for your dependents ends because you become eligible for Medicare, any active coverage for your dependents may be continued.

You must ask in writing to continue within 45 days of the date we notify your dependents of the right to continue and the date coverage would end. The request must include an agreement to pay up to 102% of the cost to this plan. Premium payments must continue.

Coverage for a dependent will not continue beyond the earliest of:

- The end of a 36 month period which starts on the date you become eligible for Medicare; except if the coverage ends during the 36 month period for employees of the eligible class that you were a member of, coverage will be continued, unless it ends for another reason, until the later of:
  - 39 weeks from the date of such discontinuance
  - the remainder of the 36 month period on the date of such discontinuance
- The date the dependent becomes eligible for the same of similar group benefits
- The end of the period for which any required contributions have not been made

If any coverage being continued ends because coverage has been continued for the maximum period, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov.

## Continuation of coverage on a loss of coverage due to a bankruptcy proceeding

Your coverage may be extended if you are a retired employee and your coverage will end or be substantially decreased because your former employer has started bankruptcy proceeding under Title 11, United States Code or within the 12 months prior to or following this. Each of your dependents may be eligible to continue his or her own coverage.

You or your dependents must ask in writing to continue coverage within 45 days of the date we notify you or your dependents of the right to continue or the date bankruptcy proceedings begin. The request must include an agreement to pay up to 102% of the cost to us. Premium payments must continue.

Coverage will not continue after the earliest of:

- The end of a 36 month period which starts on the date coverage would end
- The date you or your dependent become eligible for similar coverage under this plan
- The end of the period for which any required contribution was not made
- The date of the first Medicare open enrollment period following the date you or your dependent became ineligible for this plan

## Continuation of coverage due to a labor dispute

Your coverage may be extended if your coverage ends because you can't work due to a strike, lockout or labor dispute. And if the New Hampshire Insurance Code applies, you can extend your coverage during your absence from work. Your coverage may continue for up to 6 months after the date your pay or pay and benefits is suspended or ends because of a strike, lockout or labor dispute.

Coverage will continue until the earliest:

- You fail to make the required contributions to your employer
- Your employer fails to make the required contributions to us
- You go to work full time for another employer
- The strike, lockout or labor dispute ends
- The 6 month continuation period ends

After this 6-month period, you have the right to continue coverage for an additional 12 months as if you originally had elected to continue coverage under the Continuing health care benefit section subject to the same conditions. At the end of the additional 12 months, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov.

The monthly premium required by us for each person's coverage will be the applicable rate in effect on the date you stop work. We have the right to change premium rates under the terms of this plan with 60 days notice.

## Continuing health care benefits

**Part I**

When you or your dependents lose coverage under this plan for any reason, except gross misconduct, coverage may be continued.

You must request to continue coverage within 45 days of when we notify you of the right to continue and the date coverage would otherwise end, whichever is later. The request must include an agreement to pay up to

102% of the cost to this plan. Premium payments must continue.

Coverage will not be continued beyond the earliest of:

- The end of an 18 month period which starts on the date coverage would have ended
  - If you or your dependent tell your employer that you or your dependent are disabled under Title II or XVI of the Social Security Act within the first 60 days your coverage would have ended, except for under this section, coverage for you and your dependents will continue, unless it ends for another reason, for 29 months, which starts on the date coverage would have ended.
- The date you become eligible for the same or similar group benefits
- The end of the period for which any required contributions have not been made

Coverage for a dependent will not be continued beyond the date it would otherwise end.

**Part II**

If coverage would end because coverage has ended for the class of employees that you are in, coverage under this plan may continue for you and your dependents. You must ask to continue within 45 days of when we tell you about continuation or the date your coverage ends, whichever is earlier. You must also agree to pay up to 102% of the cost to us. Premium payments must continue.

Coverage will end on the earlier of:

- The date you are eligible for same of similar group benefits
- The end of the period for which any contributions have been made
- The end of a period equal to 39 weeks, less the number of weeks your coverage was continued under this plan during a strike, lockout or labor dispute.
  - If coverage is being continued as stated in Part I at the time coverage ends for your eligible class, coverage will be continued for up to the remainder of the 18 or 29 month period stated in Part I.

**Part III**

If any coverage being continued under Part I or Part II ends because coverage has been continued for the maximum period, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov.

## Continuation of coverage for your spouse or former spouse

**Part I**

If coverage for your dependent spouse ends because of divorce (or legal separation), the former spouse may continue to be covered. The former spouse is eligible for coverage while policy remains active or is replaced by another policy covering the member. Premium payments must continue. Coverage will not continue beyond the earliest of the:

- 3-year (36 month) anniversary that divorce or legal separation is finalized
- Remarriage of former spouse
- Remarriage of member
- Death of member
- Date that coverage ends as stated in the final divorce or legal separation.

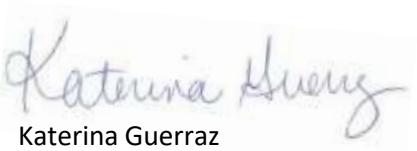
**Part II**
If coverage for your former spouse ends because of one of the reasons listed under Part I, the former spouse may continue coverage, except if the former spouse remarries. The former spouse must ask in writing for coverage within 30 days from the date coverage ends except if the former spouse remarries. The former spouse is eligible for coverage for an additional 36 months. If former spouse is 55 years or older, coverage must continue until spouse is eligible under another employer-based group plan or becomes eligible for Medicare.

Except for when former spouse is age 55 or older, coverage will not continue beyond the first to occur:

- The end of the 36-month period
- The end of the period for which required contributions have been made

**Part III**
If any coverage continued under Part I or Part II ends because coverage has been continued for the maximum period, the former spouse may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: New Hampshire Medical ET
Issue Date: December 5, 2024

**The State of New Hampshire**
**Insurance Department**
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

# CONSUMER GUIDE TO EXTERNAL APPEAL

**What is an External Appeal?**

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

**What are the eligibility requirements for External Appeal?**

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and
  have received a final, written decision from the insurer relative to its review.
  - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.

- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

**What types of health insurance are excluded from External Appeal?**

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
  - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

**Can someone else represent me in my External Appeal?**

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

**Submitting the External Appeal:**

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

**Please submit the following documentation**:

☐ The completed External Review Application Form - signed and dated on page 6.
**** The Department cannot process this application without the required signature(s) ****

☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.

☐ A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.

☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.

☐ If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

**Mailing Address:**

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

**Expedited External Review Applications**

- **May be faxed to (603) 271-1406, or**
- **Sent by overnight carrier to the Department's mailing address.**

**What is the Standard External Appeal Process and Time Frame for receiving a Decision?** It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
  - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
  - To request a "teleconference," complete Section VII of the application form entitled "Request for a Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO's review decision.

**What is an Expedited External Appeal?**

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

**What happens when the Independent Review Organization makes its decision?**

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

**Have a question or need assistance?**
**Staff at the Insurance Department is available to help.**
**Call 800-852-3416 to speak with a consumer services officer.**

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**Insurance Department**

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# INDEPENDENT EXTERNAL REVIEW

**Appealing a Denied Medical or Dental Claim**

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

**Have a question or need assistance?**
**Staff at the Insurance Department is available to help. Call 800-852-3416 to speak with a consumer services officer.**

## SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- ☐ The enclosed, completed application form - signed and dated on page 6.
  **** The Department cannot process this application without the required signature(s) ****
- ☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- ☐ A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- ☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- ☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

**Mailing Address:**

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

**Expedited External Review applications may be faxed to (603) 271-1406 or sent by sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.**

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# EXTERNAL REVIEW APPLICATION FORM
## Request for Independent External Appeal of a Denied Medical or Dental Claim

**Section I – Applicant Information**

Patient's Name: _____ Patient's Date of Birth: _____

Applicant's Name: _____Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____) _____

---

**Section II – Appointment of Authorized Representative**

** Complete this section, only if someone else is representing the patient in this appeal **

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____
Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City: _____State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: ( __ )_____ Evening: ( __ )_____

## Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID#: _____ Claim Reference#: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: ( _____ ) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes: _____ No: _____

- Name of Employer: _____
- Employer's Phone Number: (_ ) _____
- Treating Provider's Phone Number: ( ) _____
- Is the employer's insurance plan self-funded? Yes*: _____ No: _____

* If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.

### New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes _____ No _____

***If yes, please provide the Medicaid ID number & complete the following records release:***

Medicaid ID Number: _____

I,_____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

## Section IV – Information about the Patient's Health Care Providers

**Name of Primary Care Provider (PCP):** _____

PCP's Mailing Address: _____

City: _____ State: ___ Zip Code: _____

PCP's Phone Number: ( ____)_____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: ___ Zip Code: _____

Treating Provider's Phone Number: ( ___ ) _____

## Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

**Please <u>attach</u> the following:**

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Continued on next page*

## Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes _____ No _____

**Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.**

## Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes _____ No _____

My reason for requesting a phone conference is:

## VIII – Authorization and Release of Medical Records

I,_____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

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**Before submitting this application, please verify that you have**

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

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# PROVIDER'S CERTIFICATION FORM

**For Expedited Consideration of a Patient's External Review**

## NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is
within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

## GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____
City: _____State: _____Zip Code: _____

Phone Number: ( ____) _____ Fax Number: ( ____) _____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

# PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: ( _____ ) _____

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date