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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARA BERTON, on behalf of herself and all others similarly situated,

Plaintiff,

v.

AETNA INC. and AETNA LIFE INSURANCE COMPANY,

Defendants.

Case No. 4:23-cv-01849-HSG

DEFENDANTS AETNA INC. AND AETNA LIFE INSURANCE COMPANY'S NOTICE OF MOTION AND MOTION TO DISMISS COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

Hearing Date: October 12, 2023
Time: 2:00 p.m.
Location: Ronald V. Dellums Federal Building, 1301 Clay Street, Oakland, CA 94612 Courtroom 2, 4th Floor

NOTICE OF MOTION AND MOTION TO DISMISS COMPLAINT

TO ALL PARTIES AND THEIR COUNSEL OF RECORD:

Please take notice that on October 12, 2023 at 2:00 p.m. or as soon thereafter as the matter may be heard, Defendants Aetna Inc. and Aetna Life Insurance Company (together, "Aetna" or "Defendants"), by and through their counsel, will and hereby do move the Court pursuant to Federal Rules of Civil Procedure 12(b)(6) and 12(b)(7) for an order dismissing Plaintiff Mara Berton's Complaint for Damages and Injunctive Relief with prejudice. Defendants' Motion is made on several independent bases.

First, Plaintiff's Complaint should be dismissed pursuant to Rule 12(b)(6) because Plaintiff does not plausibly allege intentional discrimination on the basis of sex or sexual orientation. Indeed, Plaintiff fails to plausibly allege that the denial of Plaintiff's requested treatment was discriminatory at all, since the coverage terms Plaintiff challenges apply in equal fashion to individuals outside the claimed protected class.

Second, Plaintiff's Complaint should be dismissed pursuant to Rule 12(b)(7) for failure to join her health plan's sponsor and plan administrator as a necessary party.

Third, Plaintiff's Complaint should be dismissed pursuant to Rule 12(b)(6) because the Employee Retirement Income Security Act of 1974 ("ERISA") provides the exclusive remedy for individuals who, as here, assert a claim for improper denial of benefits under an ERISA-governed health plan.

Fourth and finally, Aetna Inc. is not a proper party to this lawsuit because it does not provide health insurance and had no involvement with administering the benefit plan at issue in this litigation. It should be dismissed.

This Motion is based upon this Notice of Motion, the accompanying Memorandum of Points and Authorities; the Declarations of Craig Allocca, Robert Goldbeck, and Donna Lynch; any oral argument the Court may permit; and all pleadings and papers on file with the Court in this action and on such other matters as may be presented to the Court at or before the hearing of this Motion.

Respectfully submitted,

Dated: July 24, 2023

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES
(Continued)

Page(s)

TABLE OF AUTHORITIES
(Continued)

Page(s)

Statutes

TABLE OF AUTHORITIES
(Continued)

Page(s)

Other Authorities

Rules

MEMORANDUM OF POINTS AND AUTHORITIES

PRELIMINARY STATEMENT

Defendant Aetna Life Insurance Company ("Aetna") serves as a claims administrator for employee health benefit plans that offer benefits of the plan sponsor's choosing. The sponsor of Plaintiff's health plan (the "Plan") elected to include a benefit to treat medical infertility through intrauterine insemination ("IUI"). At the time Plaintiff was attempting to conceive, the Plan required all members seeking the benefit to confirm a diagnosis of medical infertility by showing that they unsuccessfully tried to conceive for a specific, age-related period of time through egg/sperm contact. Plaintiff is in a same-sex relationship and sought coverage for donor insemination through IUI without first establishing that she met the Plan's medical necessity criteria for infertility treatments. Her benefit claim was denied as a result. Plaintiff asserts that her Plan's "requirement" that she establish her medical infertility by paying out of pocket for multiple rounds of IUI violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116(a) ("Section 1557"), by imposing on same-sex couples costs that opposite-sex couples may avoid by attempting to conceive through heterosexual sex. Plaintiff's claim fails as a matter of law.

First, the Complaint should be dismissed under Rule 12(b)(6) because Plaintiff does not plausibly allege a violation of Section 1557's antidiscrimination protections. Section 1557 follows standards developed under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 *et seq.* ("Title IX"). To survive a motion to dismiss, Plaintiff must therefore plausibly allege intentional discrimination; she cannot proceed on a theory that a facially neutral policy has a disparate impact on a protected group. But the Plan term Plaintiff challenges was not discriminatory at all: The sponsor of Plaintiff's Plan elected to offer a benefit for the treatment of ***medical*** infertility, and the Plan's definition of medical infertility applied to all members, regardless of their relationship status or their sexual orientation. Women who were unable to attempt conception through heterosexual sex for ***any*** reason would, like Plaintiff, have had to establish medical infertility through unsuccessful insemination attempts before qualifying for this benefit. The Plan did not deny Plaintiff this benefit because she is in a same-sex relationship, but

rather because she did not meet the Plan's definition of medical infertility. And if that facially neutral policy adversely affected Plaintiff, the Complaint does not plausibly allege that the adverse effect was an intentional effort to discriminate against one protected group. While the Complaint liberally uses the term "intentional discrimination," Plaintiff does not include any allegations of ***fact*** permitting the inference that the Plan intentionally discriminated against women in same-sex relationships, nor does she plausibly allege that her Plan, in any way, treated them differently from heterosexual women who were not in a position to achieve sperm-egg contact through heterosexual intercourse.

Second, Plaintiff has failed to sue an entity that is indispensable to her claim of intentional discrimination: the Plan's sponsor and administrator, Plaintiff's wife's employer, which chose this benefit and oversaw the Plan itself. The Plan sponsor is not simply a necessary party—it is contractually the party responsible for the benefit design decisions that Plaintiff claims effected impermissible discrimination, and its plan benefit design cannot be condemned or altered without prejudice to the Plan sponsor. Plaintiff has not joined that necessary party, and could never join the innumerable other health plan sponsors (with their myriad variations in plan design) implicated by her overbroad class definitions. The Complaint should therefore be dismissed pursuant to Rule 12(b)(7).

Third, Plaintiff's Complaint should be dismissed pursuant to Rule 12(b)(6) because the Employee Retirement Income Security Act of 1974 ("ERISA") provides the exclusive remedy for Plan members who assert a claim for improper denial of benefit payments under the Plan. To the extent that Plaintiff contends her Plan should be construed to cover IUI treatments irrespective of whether the member had been diagnosed with medical infertility, that claim must be asserted through an ERISA claim for benefits.

Fourth and finally, Aetna Inc. is not a proper party to this lawsuit and should be dismissed. Aetna Inc. is a holding company that has no insurance operations or products, is not licensed to sell insurance, and had no involvement with or responsibility for administering Plaintiff's benefit Plan. Plaintiff's Complaint makes no independent allegations against Aetna Inc. and fails to state

a claim against it pursuant to Rule 12(b)(6).

For all these reasons, and as explained in detail below, Aetna respectfully requests that the Court grant this Motion and dismiss Plaintiff's Complaint in its entirety.[1]

STATEMENT OF FACTS

A. The Parties

Plaintiff is a 32-year-old woman in a same-sex relationship. Compl. ¶ 13 & n.2. Since September 2021, Plaintiff has been enrolled in an employee health benefit plan sponsored by her wife's employer, Encore Group USA LLC ("Encore"). *Id.* ¶ 52. Defendant Aetna Life Insurance Company serves as third-party administrator of the Plan. Defendant Aetna Inc. is a holding company that has no insurance operations or products and is a parent company of Aetna Life Insurance Company. Declaration of C. Allocca i/s/o Defendants' Mot. to Dismiss Complaint, dated July 20, 2023 ("Allocca Decl.") ¶ 4; *see also* ECF No. 30.

B. The Encore Plan and Relationship Between Encore and Aetna[2]

The Encore Plan is a self-insured plan governed by ERISA. Compl. ¶ 52. Pursuant to the Master Services Agreement between Encore and Aetna Life Insurance Company, Encore is the Plan administrator and Plan fiduciary under ERISA. Ex. A to the Declaration of Robert Goldbeck i/s/o Defendants' Mot. to Dismiss, dated July 24, 2023 ("Goldbeck Decl."), Master Services

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[1] Aetna recognizes that not all women have uteruses. For brevity and clarity, Aetna uses the term here as a proxy for individuals who are biologically capable of bearing children.

[2] The Court may consider the documents incorporated into the Complaint in connection with Aetna's motion to dismiss under Rule 12(b)(6). *See, e.g.*, *Tellabs, Inc. v. Makor Issues & Rts., Ltd.*, 551 U.S. 308, 322 (2007); *Khoja v. Orexigen Therapeutics, Inc.*, 899 F.3d 988, 1002 (9th Cir. 2018) (recognizing incorporation-by-reference doctrine); *Whitaker v. LL S. S.F., L.P.*, 2021 WL 2291848, at *3 (N.D. Cal. June 4, 2021) (on motion to dismiss, court may consider documents that "plaintiff refers extensively to" or that "form[] the basis of plaintiff's claims"). Here, that includes the Master Services Agreement, the Summary Plan Description, the relevant Clinical Policy Bulletin, and benefit claim discussed in the Complaint. *See* Compl. ¶¶ 28, 30 (citing language in infertility-related Clinical Policy Bulletin); *id.* ¶ 52 (discussing Plaintiff's enrollment in the "Aetna-administered Encore Group Policy"); *id.* ¶¶ 57-63 (discussing Plaintiff's request for preauthorization of IUI cycles and subsequent denial and appeals). The Court may also consider extrinsic evidence in evaluating a Rule 12(b)(7) motion to dismiss. *See Potter v. Chevron Prods. Co.*, 2018 WL 4053448, at *4 (N.D. Cal. Aug. 24, 2018) ("[T]he court may consider evidence outside of the pleadings" on a Rule 12(b)(7) motion to dismiss) (citing *McShan v. Sherrill*, 283 F.2d 462, 464 (9th Cir. 1960)).

Agreement (referred to herein as the "MSA") Ex. A Art. 3.01; *see also id.* Art. 1 (defining "Plan Administrator" as Encore and stating "[t]his term will never refer to Aetna under this Agreement"; defining "Plan Fiduciary" as Encore and stating that Encore "bears ultimate responsibility and liability for the health plan under ERISA . . ."). Encore is also the Plan sponsor, and the MSA specifically provides that in no event shall Aetna be considered the named fiduciary of the Plan or its sponsor. *Id.* Art. 3.02. The MSA further provides that:

> ***It is understood and agreed that [Encore], as Plan Administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided thereunder***, and that Aetna is empowered to act on behalf of [Encore] in connection with the Plan only to the extent expressly stated in this Agreement or as agreed to in writing by Aetna and [Encore].

Id. Art. 3.01 (emphasis added). In brief, Encore has sole authority to set the terms of the Plan and determine who is eligible for benefits under it.

Aetna Life Insurance Company provides third party claims administration services to the Plan. *Id.* Art. 1; *Id.* Art. 3.02. Pursuant to the MSA, Encore has delegated discretionary authority to Aetna "to determine initial entitlement to benefits under the applicable Plan documents for each claim received" and to "review[] denied claims under the Plan." *Id.* Art. 3.02. Aetna is responsible for "reviewing denied claims under the Plan." *Id.* In discharging these services, Aetna is required to act "in a manner consistent with the documents and instruments governing the Plan." *Id.*

C. Infertility Benefits Under the Plan

Because Plaintiff sought benefits in February 2022, the plan document that governed the determination of her benefit claim was the Encore Plan Summary Plan Description ("SPD") effective January 2022.[3]

The Plan generally provides coverage for "medically necessary" services, *see* SPD at 34, and specifically provides coverage for certain infertility treatments: (1) "Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries"; and (2) "Artificial

[3] This version of the Plan updates an SPD adopted in 2019; plan sponsors may periodically update the benefits, including infertility benefits, they opt to include in their plans. *See* Ex. B to the Goldbeck Decl. (referred to herein as the "SPD") at 14.

insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination." *Id.* at 10. The Plan excludes from coverage several other types of infertility treatment, including in vitro fertilization (IVF), costs associated with gestational carrier or surrogacy arrangements, and the purchase of donor embryos, donor eggs, or donor sperm. *Id.* at 11.

A Plan member is eligible for covered infertility services when the member or their partner has been medically diagnosed with the disease of infertility. *Id.* Under the Plan's definition of "infertility," any individual may demonstrate medical infertility by attempting conception for the requisite period through egg/sperm contact, whether through unprotected sexual intercourse or through donor insemination, and (for females) by meeting certain hormonal testing criteria defined in the Plan.[4] *Id.*[5]

In its role as claims administrator of self-insured benefits plans like the Encore Plan, Aetna may develop "clinical policy bulletins" or "CPBs" that aid physician reviewers in the application of plan terms to individual benefit claims. SPD at 36; *Clinical Policy Bulletins*, Aetna, https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. One such bulletin aids reviewers in the application of the definition of medical infertility employed in certain Aetna-administered plans. *Clinical Policy Bulletin No. 0327*, Aetna (effective May 20, 1999), https://www.aetna.com/cpb/medical/data/300_399/0327.html. The bulletin in effect at the time Plaintiff submitted her claim for benefits in 2022 (Clinical Policy Bulletin 0327, or "CPB 327") tracked the definition of infertility in the Encore Plan, providing as follows:

[A] member is considered infertile if he or she is unable to conceive or produce

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[4] The period of attempted conception through egg/sperm contact varies by age: 12 months for females under age 35, 6 months for females above it. SPD at 57-58.

[5] This definition comports with definitions of infertility established by professional medical organizations. The American College of Obstetricians and Gynecologists (ACOG), the World Health Organization (WHO), and the American Society for Reproductive Medicine (ASRM) define infertility as the failure to achieve a pregnancy after 1 year (or 6 months for individuals over the age of 35) of regular unprotected sexual intercourse. *See Treating Infertility Frequently Asked Questions*, Am. Coll. Of Obstetricians and Gynecologists (2023), https://www.acog.org/womens-health/faqs/treating-infertility; *Infertility*, World Health Org. (Apr. 3, 2023), https://www.who.int/news-room/fact-sheets/detail/infertility; *Infertility Resources*, Am. Soc'y for Reproductive Med., https://www.reproductivefacts.org/browse-all-topics/infertility-topic/ (last accessed June 22, 2023).

> conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older).

Compl. ¶ 28.[6] Plaintiff refers to this CPB as Aetna's "Infertility Policy," *id.* ¶ 25; the CPB implements the Plan terms outlined above. Under the Plan and the implementing CPB, egg-sperm contact can be achieved by frequent sexual intercourse or through monthly cycles of timed sperm insemination (intrauterine, intracervical, or intravaginal). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a reproductive partner.

D. Plaintiff's Request for IUI Coverage

In January 2022, Plaintiff and her wife decided to try to have children by having Plaintiff, who was 30 years old at the time, become pregnant using IUI with donor sperm. Compl. ¶ 57. In February 2022, Plaintiff's fertility clinic submitted a claim to Aetna for preauthorization for up to six IUI cycles. *Id.* ¶ 58. Plaintiff does not allege that she had been diagnosed with medical infertility at the time she requested this benefit. On February 21, 2022, Aetna informed Plaintiff via letter that the request for IUI coverage was denied because she did not meet the Plan definition of infertility. Ex. A to the Declaration of Donna Lynch i/s/o Defendants.' Mot. to Dismiss, dated July 24, 2023 ("Lynch Decl."). The letter explained that the denial "was based on the terms of [Plaintiff's] benefit plan document" and referred Plaintiff to "the description of infertility benefits in the section of the plan document that talks about what the plan covers." *Id.*

Plaintiff appealed that benefit determination in June 2022. Compl. ¶ 61; Ex. B to the Lynch Decl. In the appeal, Plaintiff claimed the definition of "infertility" in the Encore Plan and in the applicable CPB discriminated against her. Dr. Andrea Jones, a medical director at Aetna and board-certified OB/GYN, reviewed Plaintiff's file and determined the coverage denial should be upheld because Plaintiff did not meet the Plan's definition of medical "infertility." Ex. F to the

[6] In January 2023, Aetna revised the pertinent CPB to provide as follows: "[A] person is considered infertile if unable to conceive or produce conception after 1 year of egg-sperm contact when the female attempting conception is under 35 years of age, or after 6 months [of] egg-sperm contact when the female attempting conception is 35 years of age or older." Compl. ¶ 30.

Lynch Decl. at 4-5. On June 30, 2022, Aetna issued a letter to Plaintiff explaining its decision to uphold the denial of coverage based on the Plan's definition of infertility and because the requested IUI cycles did not meet the definition of "medical necessity" under the Plan SPD. *Id.* Ex. C.

In August 2022, Plaintiff filed a Level-2 appeal of the benefits determination. Compl. ¶ 63; Ex. D to the Lynch Decl. In September 2022, Dr. Lara Fisher, a medical director at Aetna and board-certified OB/GYN, reviewed Plaintiff's file and determined the coverage denial should be upheld because Plaintiff had not been diagnosed with medical infertility and did not meet the definition of medical "infertility" set forth in the Plan. Ex. E to the Lynch Decl.; Ex. F to the Lynch Decl. at 7.

Plaintiff filed her Complaint in this Court on April 17, 2023. The Complaint alleges a single cause of action against Aetna Inc. and Aetna Life Insurance Company for discrimination in healthcare on the basis of sex under Section 1557. Compl. ¶¶ 95-102. Plaintiff seeks to bring this claim on behalf of two putative classes:

1. A "National Injunctive Relief Class" under Federal Rules of Civil Procedure 23(b)(2), defined as "All LGBTQ individuals with uteruses who are or will be Members of an Aetna health plan in the United States that includes fertility benefits and incorporates the Infertility Policy."[7]

2. A "California Damages Class" under Federal Rules of Civil Procedure 23(b)(3), defined as "All LGBTQ individuals with uteruses who, at any time in the last four years, are or were Members of an Aetna health plan in California that included fertility benefits and incorporated Aetna's Infertility Policy, and who incurred out-of-pocket expenses and/or other compensable damages as a result of Aetna's Infertility Policy."

Id. ¶¶ 76-78.

LEGAL STANDARD

A motion to dismiss pursuant to Rule 12(b)(6) challenges the sufficiency of a complaint as failing to allege "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). Facial plausibility requires "more than a sheer possibility that a defendant has acted unlawfully." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)

[7] Plaintiff defines the "Infertility Policy" to mean Aetna's description of "infertility" in Clinical Policy Bulletin No. 0327. Compl. ¶ 25.

(internal quotations and citations omitted). To survive a motion to dismiss, a plaintiff must allege sufficient facts to make her claim plausible. *Twombly*, 550 U.S. at 555, 570 (complaint must offer "more than labels and conclusions, and a formulaic recitation of the elements"); *Iqbal*, 556 U.S. at 678 ("A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.").

Section 1557 incorporates and follows the legal standards developed under Title IX for claims alleging discrimination on the basis of sex. *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1210 (9th Cir. 2020), *cert. dismissed*, 142 S. Ct. 480 (2021). Under those standards, to state a claim for discrimination on the basis of sex under Section 1557, Plaintiff must adequately allege that the discrimination at issue was intentional—the statutory prohibition does not reach activities that merely have a disparate impact on a protected group. *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 173 (2005) (explaining that Title IX prohibits "intentional sex discrimination," and discussing cases elaborating that standard).[8] Conclusory allegations of intentional discrimination—such as merely labeling discrimination as "intentional"—are insufficient to survive a motion to dismiss. *Austin v. Univ. of Oregon*, 925 F.3d 1133, 1138 (9th Cir. 2019) ("A recitation of facts without plausible connection to gender is not cured by labels and conclusory statements about sex discrimination").[9] To adequately plead intentional discrimination, a party must assert "nonconclusory allegations" that "plausibly link[]" the alleged discrimination to the

[8] *See also Oona R.-S. by Kate S. v. Santa Rosa City Sch.*, 890 F. Supp. 1452, 1466 & n.8 (N.D. Cal. 1995) (recognizing that "intentional discrimination is an element of a Title IX claim" alleging discriminatory treatment); *Doe v. Regents of Univ. of Cal.*, 2017 WL 4618591, at *14 (C.D. Cal. 2017) ("A claim under Title IX cannot be premised on the disparate impact a policy has with respect to a protected group"), *rev'd on other grounds*, 891 F.3d 1147 (9th Cir. 2018).

[9] *See also Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967, 989 (N.D. Cal. 2018) (plaintiffs' allegations that defendants' "intentionally discriminatory actions" denied them full and equal enjoyment of certain health benefits insufficient to survive motion to dismiss), *vacated in part on other grounds*, 982 F.3d at 1204, *cert. dismissed*, 142 S. Ct. 480; *Esonwune v. Regents of Univ. of Cal.*, 2017 WL 4025209, at *5-6 (N.D. Cal. Sept. 13, 2017) (allegations that university treated plaintiff differently in school disciplinary proceedings and exhibited "deliberate indifference" to allegedly discriminatory impact insufficient to survive motion to dismiss); *Massey v. Biola Univ., Inc.*, 2020 WL 5898804, at *6 (C.D. Cal. Aug. 21, 2020) (dismissing Title IX claim for failure to assert non-conclusory allegations of discrimination).

protected characteristic. *Austin*, 925 F.3d at 1138.

Rule 12(b)(7) requires dismissal for "failure to join a party under Rule 19." Analyzing a Rule 12(b)(7) motion involves three successive inquiries: (1) is the absent party necessary (i.e., required to be joined if feasible) under Rule 19(a); (2) if so, whether it is feasible to order that absent party to be joined; and (3) if joinder is not feasible, whether the case can proceed without the absent party, or whether the absent party is indispensable such that the action must be dismissed. *Salt River Project Agric. Improvement & Power Dist. v. Lee*, 672 F.3d 1176, 1179 (9th Cir. 2012); *Zurich Am. Ins. Co. v. Elecs. For Imaging, Inc.*, 2009 WL 2252098, at *4-5 (N.D. Cal. July 28, 2009) (granting Rule 12(b)(7) motion to dismiss for failure to join necessary and indispensable parties).

ARGUMENT

I. PLAINTIFF FAILS TO STATE A CLAIM FOR DISCRIMINATION ON THE BASIS OF SEX UNDER SECTION 1557.

Plaintiff's Section 1557 claim fails because Plaintiff has not alleged (and cannot allege) that the Plan term and implementing CPB under which she was denied coverage for IUI violated Section 1557. Plaintiff does not plausibly allege that the denial of IUI amounted to intentional discrimination. Indeed, Plaintiff fails to allege that denial was based on her membership in a protected group at all. As explained in detail below, these critical defects require dismissal.

To state a claim of discrimination under Section 1557, Plaintiff must satisfy the pleading standard for intentional discrimination under Title IX. *Supra* at p.8. As an initial matter, a Title IX plaintiff must plead, and eventually prove, that the defendant's alleged intentional discrimination was "because of her sex[.]" *Oona*, 890 F. Supp. at 1466 n.12; *Austin*, 925 F.3d at 1138. Sex discrimination is "intentional" under Title IX when differential treatment is motivated by discriminatory animus toward the protected group, or, in limited, specific circumstances, when a defendant is deliberately indifferent to a third-party's discriminatory conduct. *See, e.g.*, *Austin*, 925 F.3d at 1137-38; *Lopez v. Regents of Univ. of Cal.*, 5 F. Supp. 3d 1106, 1120 (N.D. Cal.

2013).[10] To survive a motion to dismiss, it is not enough for Plaintiff merely to label the alleged discrimination she experienced as "intentional." *Esonwune*, 2017 WL 4025209, at *5-6; *Massey*, 2020 WL 5898804, at *6. Rather, Plaintiff must allege ***facts*** that plausibly support a theory of intentional discrimination. *Twombly*, 550 U.S. at 570; *Iqbal*, 556 U.S. at 678.

Here, Plaintiff cannot point to ***any*** differential treatment "because of" sex or sexual orientation, let alone ***intentional*** mistreatment. The Plan's definition of infertility treats all persons seeking infertility treatments the same—they all must satisfy the definition of medical infertility, which requires a showing of unsuccessful conception through sperm/egg contact over a period of time. That term applies irrespective of the relationship, if any, a person is in. And it is not just women in same-sex relationships who may be unable to attempt sperm/egg contact through heterosexual sex. Single heterosexual women who wish to become parents on their own; heterosexual couples (including men and women) with conditions which make intercourse physically or medically impossible for the purpose of achieving a pregnancy; and heterosexual individuals (again, men or women) who wish to co-parent in a platonic relationship—under the Plan term in effect at the time Plaintiff sought coverage, all of these individuals would have had to demonstrate medical infertility through means other than attempts at conception through heterosexual intercourse. Put another way, Plaintiff does not (and cannot) plausibly allege she was ***singled out*** for different treatment, when other individuals—including deployed military personnel, single women, and persons with conditions precluding heterosexual intercourse, as examples—must meet the conditions for coverage the same way. Under the terms of the Encore Plan, ***any*** woman who pursued IUI treatment without first meeting the medical infertility criteria in the Plan would be denied coverage for infertility treatment, just as Plaintiff was. Given this entirely neutral policy, Plaintiff cannot plausibly allege that the Plan's definition of "infertility"

[10] "Deliberate indifference" is not an alternative to intent, but rather a form of intentional discrimination that occurs when a federal funding recipient fails to remedy discriminatory conduct of which it has actual notice. *See, e.g.*, *Davis Next Friend LaShonda D. v. Monroe Cty. Bd. of Educ.*, 526 U.S. 629, 642-43 (1999) (explaining that the "deliberate indifference" standard imposes liability for "effectively 'caus[ing]' the discrimination" by another (quoting *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 291 (1998)).

imposes a unique burden specifically on women in same-sex relationships, because any person, regardless of sexual orientation, may need to incur costs under some circumstances in order to establish medical infertility.

Plaintiff's contention that this Plan term imposes burdens on women in same-sex relationships is at best a ***disparate impact*** theory of discrimination, which is insufficient to state a claim under Section 1557 or Title IX. *Condry v. UnitedHealth Grp., Inc.*, 2018 WL 3203046, at *4 (N.D. Cal. June 27, 2018) ("[D]isparate impact claims on the basis of sex are not cognizable under section 1557."), *vacated in part on other grounds*, 2021 WL 4225536 (9th Cir. Sep. 16, 2021); *see also Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 739 (N.D. Ill. 2017) (holding "Plaintiffs cannot proceed with a disparate-impact claim under § 1557, which incorporates Title IX's enforcement mechanism for sex discrimination claims").[11] And Plaintiff does not plausibly allege that Aetna administered this Plan term out of animus to women in same-sex relationships (or knowing deliberate indifference to the sponsor's selection of the Plan term out of animus). Plaintiff does not contend that an unsuccessful period of sperm/egg contact is itself an unreasonable means of diagnosing medical infertility. Nor does she challenge her Plan's exclusion of the cost of donor sperm or other ancillary charges, which are also inherent costs to accomplishing conception through means other than intercourse. Plaintiff does not challenge the notion that this is a Plan term grounded in conventional medical criteria and that applies equally to all Plan members. Furthermore, the Complaint alleges no facts permitting the conclusion that the Plan term was adopted in order to single out women who are in same-sex relationships.

In the absence of factual allegations that Aetna administered this Plan term out of animus or in a manner that was knowingly deliberately indifferent to animus, Plaintiff is left to allege that "Aetna has received countless complaints and criticisms of its Infertility Policy, and when

[11] Disparate impact (i.e., unintentional) theories of discrimination are not cognizable under Title IX in part because statutes enacted pursuant to the Spending Clause "operate[] based on consent," *Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562, 1570 (2022), and a federal funding recipient is incapable of "consenting" to avoid unintentional discrimination. *See Franklin v. Gwinnett Cty. Pub. Schs.*, 503 U.S. 60, 74 (1992) ("The point of not permitting monetary damages for an unintentional violation is that the receiving entity of federal funds lacks notice that it will be liable for a monetary award.").

accused of discrimination, it has continued to treat Class Members unequally." Compl. ¶ 8. But a policy does not acquire discriminatory animus simply because someone has accused it of being unlawful.[12] A plan term adopted to implement medically appropriate clinical criteria (here, a showing of unsuccessful egg-sperm contact to diagnose medical infertility) ***still has that same purpose*** even when it is attacked as having a disparate impact. Other courts have rejected this kind of "bootstrapping" in the Section 1557 context, and this Court should too.

For example, in *Polonczyk v. Anthem BlueCross and BlueShield*, 586 F. Supp. 3d 648, 656 (E.D. Ky. 2022), the court dismissed a Section 1557 claim because the plaintiff had not adequately alleged intentional discrimination. As relevant here, the plaintiff attempted to plead intent by claiming that "she repeatedly informed Anthem of the discriminatory consequences that she was suffering as a direct result of Anthem's denials," and that Anthem "completely ignored the discriminatory effects" its decision imposed. *Id.* at 656 (alterations omitted). The court concluded that these allegations were insufficient in the absence of any additional "documents or actions" indicating animus. *Id.* Similarly, in *Weinreb v. Xerox Business Services, LLC Health and Welfare Plan*, 323 F. Supp. 3d 501, 505 (S.D.N.Y. 2018), the court considered a Section 1557 claim challenging the failure to cover off-label fentanyl use to treat a rare disease, Global Diffuse Adenomyosis ("GDA"), that affects only women. The court found the plaintiff's allegations that the health plan's coverage exclusion "discriminates against females who, as opposed to males, can suffer from GDA" and that the exclusion "provides inferior coverage to women than to men" insufficient to state a claim under Section 1557 because they were only "conclusory assertions" that "speak nothing of Defendants' intentions to interpret and apply the guidelines in a discriminatory way." *Id.* at 520-21; *see also Briscoe*, 281 F. Supp. 3d at 737-39 (dismissing Section 1557 sex discrimination claim where plaintiffs alleged that their health plan unlawfully failed to cover lactation counseling services, resulting in "disparate levels of health

[12] This is particularly salient here, in that the attorneys bringing the present action were responsible for filing a virtually identical suit in at least one other jurisdiction, *Goidel v. Aetna Life Insurance Company*, No. 1:21-cv-07619 (S.D.N.Y. filed Sept. 13, 2021), which has been accompanied by ongoing media campaigns.

benefits . . . for breastfeeding and lactating women."). These cases follow similar precedents in the Title IX context, where courts have held that allegations a school official was merely notified of potentially discriminatory conduct and failed to take action is insufficient to state a claim. *See, e.g., Lopez*, 5 F. Supp. 3d at 1123 (finding plaintiff's allegation that she "telephoned" school official and sent him an email "concerning" allegedly discriminatory incident insufficient to state a claim under Title IX because such allegations "plead no facts which explain the nature or scope of information the U.C. Regents possessed.").

The same is true here. While Plaintiff repeats the word "intentional" throughout her Complaint, she offers no factual allegations indicating actual discriminatory animus on Aetna's part. Plaintiff does not allege that Aetna (or the Plan sponsor that actually implemented this Plan term) was motivated by an intent to discriminate against same-sex couples in administering the criterion of a period of unsuccessful egg/sperm contact to diagnose medical infertility. At the end of the day, Plaintiff's complaint is that her Plan limits its benefits to the treatment of medical infertility, and does not include an additional benefit for same-sex couples to receive IUI without a diagnosis of medical infertility. But this generally applicable benefit does not discriminate on any protected ground and is not plausibly alleged to derive from any animus against same-sex couples or deliberate indifference to the Plan sponsor's animus. Simply averring that "others have also complained" does not carry Plaintiff's pleading burden. Plaintiff has therefore not adequately alleged discrimination on the basis of sex or sexual orientation, and her Section 1557 claim should be dismissed.

II. THE COMPLAINT SHOULD BE DISMISSED PURSUANT TO RULE 12(B)(7) BECAUSE PLAINTIFF EXCLUDES AN INDISPENSABLE PARTY FROM HER NATIONWIDE CLASS ACTION.

Plaintiff's Complaint should also be dismissed pursuant to Rule 12(b)(7) because Plaintiff does not and cannot join Encore, who is the self-funded plan sponsor and plan administrator of Plaintiff's Plan and the entity that selected the benefit term now claimed to be discriminatory.

Under Rule 12(b)(7), a claim or action must be dismissed where the plaintiff fails to join a necessary party under Rule 19. To determine whether a case may proceed without an absent

party, the court must analyze: (1) whether the absent party is necessary (i.e., required to be joined if feasible) under Rule 19(a); (2) if so, whether it is feasible to order that absent party to be joined; and (3) if joinder is not feasible, whether the case can proceed without the absent party, or whether the absent party is indispensable such that the action must be dismissed. *Salt River*, 672 F.3d at 1179. Here, that analysis leads straight to the conclusion that Encore is an indispensable party. Plaintiff is challenging a benefit term that was implemented by Encore. If she were to demonstrate that she is entitled to the remedies she seeks—payment of costs for medical services and a forward-looking change to the Plan—she could not obtain them without Encore's participation in this case. And Encore, for its part, would be prejudiced by being excluded from an action that not only could affect the scope of its plan and expose it to monetary liability, but also would impugn its motives in designing its health benefit plan. But Encore is not subject to jurisdiction in this district, and thus cannot feasibly be joined. Plaintiff has an available avenue for relief: a suit against Encore in a district in which it may be found. Plaintiff's Section 1557 claim here should be dismissed. *Zurich*, 2009 WL 2252098, at *4-5.

A. Encore Is a Necessary Party.

The first inquiry under Rule 12(b)(7) is whether a nonparty should be joined under Rule 19(a) as a "necessary" party. A party is necessary if: (1) complete relief cannot be granted in the party's absence; or (2) the court determines the absent party's participation "is necessary to protect its legally cognizable interests or to protect other parties from a substantial risk of incurring multiple or inconsistent obligations because of those interests." *Camacho v. Major League Baseball*, 297 F.R.D. 457, 461 (S.D. Cal. 2013) (quoting *Disabled Rts. Action Comm. v. Las Vegas Events, Inc.*, 375 F.3d 861, 878 (9th Cir. 2004)). Both criteria are present here. Encore is a necessary party to Plaintiff's Section 1557 claim because the relief Plaintiff seeks—a declaratory judgment reforming the Encore Plan and requiring it to pay additional benefits, *see generally* Compl., Prayer for Relief—should not and cannot be achieved in its absence.

Aetna is the Plan's third-party administrator. But the Encore Plan, set by Encore, determines the health benefits to which Plaintiff is entitled. Under its agreement with Aetna,

Encore "[r]etains complete authority and responsibility for the Plan, its operation, and the benefits provided thereunder." MSA Art. 3.01. While Plaintiff attributes her denial of benefits to Aetna's CPB, Compl. ¶ 25, it is the Plan document (not the CPB) that governs the Plan terms selected by the Plan sponsor. *See* SPD at 36. Aetna has no power to change the Plan definition of "infertility" that led to Plaintiff's benefits claim being denied. Moreover, the Encore Plan is self-funded, meaning it covers the cost of benefit claims itself and simply relies on its third-party administrator, Aetna, to process those claims and payments.[13] *Williby v. Aetna Life Ins. Co.*, 867 F.3d 1129, 1131 (9th Cir. 2017); *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990) (describing self-funded plans). Any claim seeking additional benefits necessarily implicates Encore's purse.

Because Plaintiff seeks relief that would rewrite the terms of the Encore Plan and/or require payment of specific benefits under the Plan, without joining Encore, "the court cannot accord complete relief among existing parties" and proceeding without Encore "may . . . as a practical matter impair or impede [their] ability to protect" its legal interests. *See* Fed. R. Civ. P. 19(a)(1)(A)-(B). This is a textbook case for the application of Rule 19. Plaintiff has not simply failed to join a necessary party to her Complaint—she has failed to join the ***only*** party who has authority to make the decisions put at issue in Plaintiff's case.

B. Encore Cannot Be Feasibly Joined.

The second Rule 12(b)(7) inquiry is whether it is feasible for the absent necessary party to be joined. *Salt River*, 672 F.3d at 1179. Joinder is not feasible when venue is improper or when the absent party is not subject to personal jurisdiction. *E.E.O.C. v. Peabody W. Coal Co.*, 610 F.3d 1070, 1078 (9th Cir. 2010). Here, joinder of Encore is not feasible because Plaintiff cannot establish that Encore is subject to personal jurisdiction or venue in this district. *AirWair Int'l Ltd. v. Schultz*, 73 F. Supp. 3d 1225, 1232 (N.D. Cal. 2014) (a court may exercise personal jurisdiction

[13] In the context of an ERISA self-funded plan, the plan "sponsor," which ERISA generally defines as "the employer," *see* 29 U.S.C. § 1002(16)(b), is the party that establishes or maintains the ERISA plan and its terms. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78-79 (1995). The self-funded "plan administrator" (distinct from a claims administrator) is the entity so designated by the ERISA plan; and if the plan fails to designate one, it is the plan sponsor by default. 29 U.S.C. § 1002(16)(a). Here the plan sponsor and plan administrator is Encore. MSA Art. 1; *id.* Art. 3.01.

over a non-resident defendant only when (1) the defendant has minimum contacts with the state sufficient to justify the court's exercise of jurisdiction; and (2) exercising jurisdiction comports with traditional notions of fair play and substantial justice); *Knuttel v. Omaze, Inc.*, 572 F. Supp. 3d 866, 869 (N.D. Cal. 2021) (venue is proper in the district where "a substantial part of the events or omissions giving rise to the claim occurred," and this inquiry focuses on the "relevant activities of the defendant, not of the plaintiff." (quotations omitted)).

Encore is registered in Delaware and maintains its primary office in Illinois. The self-funded Encore Plan was created in Illinois (where Encore is located) and therefore, the Plan is funded and all benefits are presumptively paid through Encore's operations in Illinois. The MSA which establishes the relationship between Encore and Aetna and pursuant to which the Plan was created specifies that "sole and exclusive venue" shall lie in Delaware. MSA Art. 32.13. There are no facts before the Court permitting the conclusion that Encore is subject to either personal jurisdiction or venue for a Section 1557 claim in the Northern District of California. *See AirWair*, 73 F. Supp. 3d at 1232; *Knuttel*, 572 F. Supp. 3d at 869.[14]

C. Encore Is An Indispensable Party.

The third and final inquiry under Rule 12(b)(7) is whether the case can proceed without the absent party, or whether the absent party is "indispensable" such that the action must be dismissed. *Salt River*, 672 F.3d at 1179. Under Rule 19(b), indispensable parties are parties "who not only have an interest in the controversy, but an interest of such a nature that a final decree cannot be made without either affecting that interest, or leaving the controversy in such a condition that its final termination may be wholly inconsistent with equity and good conscience." *Camacho*, 297 F.R.D. at 463 (quotations omitted). Courts weigh four factors in determining whether a party is indispensable: (1) the extent to which a judgment rendered in the party's

[14] If Encore were subject to suit in this District, it would have to be joined to this litigation—but Aetna would still have to be dismissed, because it is not the party responsible for adopting the Plan term alleged to be discriminatory, as discussed in the text. And if Plaintiff's class claim were to proceed, she would never be able to feasibly join the multitude of other plan sponsors encompassed by her overbroad putative classes, whose interests would equally be implicated by her attempt to reform plan terms and impose monetary liability in a broadside attack on Aetna.

absence might prejudice that party or the existing parties; (2) the extent to which any prejudice could be lessened or avoided; (3) whether a judgment in the party's absence would be adequate; and (4) whether the plaintiff would have an adequate remedy if the action were dismissed for non-joinder. *White v. Univ. of Cal.*, 2012 WL 12335354, at *10 (N.D. Cal. Oct. 9, 2012) (citing Fed. R. Civ. P. 19(b)).

Here, as explained, the relief Plaintiff seeks cannot be meaningfully awarded without Encore's participation, since Encore has sole and complete authority over the Plan. Encore cannot be ordered to reform the terms of its Plan without being party to this case. ERISA-covered health benefits plans such as the Encore Plan are contracts which courts interpret "[b]ased on general rules of contract interpretation." *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008). No "procedural principle is more deeply imbedded in the common law than that, in an action to set aside a lease or a contract, all parties who may be affected by the determination of the action are indispensable." *Lomayaktewa v. Hathaway*, 520 F.2d 1324, 1325 (9th Cir. 1975); *see also Peabody W. Coal Co.*, 610 F.3d at 1081-82; *Kermanshah v. Kermanshah,* 2010 WL 1904135, at *3 (S.D.N.Y. May 11, 2010) (noting that where equitable relief is sought in addition to money damages, "the presence of all parties is necessary"). This Court has specifically recognized that "independent plan fiduciaries are likely indispensable parties to an action that would affect their agreements." *Baird v. Blackrock Institutional Tr. Co., N.A.*, 2020 WL 7389772, at *11 n.15 (N.D. Cal. Feb. 11, 2020); *see also In re Lowenschuss*, 171 F.3d 673, 677–78 (9th Cir. 1999) (allowing pension plan trustee to intervene in action that "directly affect[ed] the potential obligations and liabilities of the Pension Plan Trustee.").

As a party who cannot be feasibly joined, Encore would also be prejudiced by being unable to defend its interests in this case. *See* Fed. R. Civ. P. 19(b)(1)-(2).[15] Encore must have

[15] Nor can Encore be required to waive legitimate objections to personal jurisdiction or venue in order to mitigate this prejudice. *See A10 Networks, Inc. v. Brocade Commc'ns Sys., Inc.*, 2012 WL 1932878, at *10 (N.D. Cal. May 29, 2012) (rejecting plaintiffs' contention that absent parties over whom the court's basis for personal jurisdiction was "questionable" could simply "waive any objections as to personal jurisdiction" to permit joinder).

the opportunity to defend the Plan terms it adopted, or modify them if it chooses. Since Encore is responsible for all payments under the Plan, it must have the opportunity to offer its own defense against Plaintiff's claims for compensatory damages from plan assets. This is especially true where, as here, a plaintiff seeks forward-looking equitable relief. Indeed, however this action resolves, Encore faces the risk of follow-on litigation based on rulings in this case. Courts in this district have dismissed actions under Rule 19 for this exact reason. *See Weiss v. Perez*, 602 F. Supp. 3d 1279, 1297 (N.D. Cal. 2022) (granting motion to dismiss for failing to join Native American tribe as indispensable party, and noting tribe could face subsequent litigation regarding the subject matter of the lawsuit); *Hammons v. Wells Fargo Bank, N.A.*, 2015 WL 9258092, at *7 (N.D. Cal. Dec. 18, 2015) (granting motion to dismiss for failure to join co-signor to loan agreement as an indispensable party in part because co-signor's "absence creates a significant risk of repeated litigation." (alterations and quotations omitted)).

In all, this case is similar to *Takeda v. Northwestern National Life Insurance Co.*, 765 F. 2d 815 (9th Cir. 1985), where the court held that the employer–administrator of a self-funded health plan was a necessary and indispensable party. The court reasoned that (1) the employer had final authority to determine whether to allow a claim, and thus complete relief might not be possible without it, and (2) there was a risk of prejudice if the employer was not joined because there was a risk that it could be collaterally estopped from relitigating issues decided against it. *Id.* at 819-21; *see also Cuevas v. Joint Benefit Tr.*, 2013 WL 3578496, at *3 (N.D. Cal. July 12, 2013) ("That a plaintiff may assert an ERISA claim against parties other than … the plan administrator in no way precludes a finding that … [the] administrator is a necessary party…."); *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1153 (C.D. Cal. 2015) ("[F]ormally designated and de facto plan administrators are proper defendants in an ERISA benefits action.").

In another similar case, *Sypher v. Aetna Insurance Co.*, 2014 WL 1230028 (E.D. Mich. Mar. 25, 2014), the plaintiff (like Plaintiff here) sued only the claims administrator, but not the plan sponsor or plan administrator, under her ERISA-governed plan. The court held that the plan

sponsor/administrator was an indispensable party under Rule 19: "Aetna [as claims administrator] … is not the Plan Administrator, and it does not pay the claims. Rather, Federal Express is self-insured, and it, not Aetna, both funds the Plan and pays benefits. Federal Express is designated as the Plan Administrator under the explicit terms of the Plan." *Id.* at *4. The plaintiff's failure to join the plan administrator necessitated dismissal of the suit: "Plaintiff has not joined Federal Express, the Plan Administrator, as a party. Because Plaintiff seeks benefits, and because those benefits would be paid by Federal Express, (1) the Court cannot grant complete relief in the absence of Federal Express, and (2) Federal Express cannot protect its interests in the absence of joinder. Thus, Federal Express is a necessary party under Rule 19, and Plaintiff's failure to join Federal Express necessitates dismissal under Rule 12(b)(7)." *Id.* at *5.

In sum, Plaintiff has failed to join Encore as a necessary and indispensable party to her claim, and there is no practical way to join that party to this case or afford complete relief on Plaintiff's claim against Aetna alone. Plaintiff's Complaint should be dismissed. *Salt River*, 672 F.3d at 1179; *Zurich*, 2009 WL 2252098, at *4-5.

III. PLAINTIFF FAILS TO STATE A CLAIM UNDER SECTION 1557 BECAUSE ERISA PROVIDES THE EXCLUSIVE REMEDY FOR THE RELIEF PLAINTIFF SEEKS.

Plaintiff's Section 1557 claim should also be dismissed because it is not the proper vehicle to seek an award of benefits dollars under the Encore Plan. For ERISA-covered plans like the Encore Plan, ERISA's civil enforcement provisions provide the exclusive remedies for plan members who assert claims for improper processing of benefits. 29 U.S.C. § 1132(a)(1)(B); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (noting "clear congressional intent to make the ERISA remedy exclusive"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 42 (1987) ("The language and structure [of ERISA's civil enforcement] provisions support the conclusion that they were intended to provide exclusive remedies for ERISA-plan participants and beneficiaries asserting improper processing of benefit claims."); *Lea v. Republic Airlines, Inc.*, 903 F.2d 624, 632 (9th Cir. 1990) ("Claims relating to ERISA plans must [] invoke the specific remedies of ERISA.").

Aetna is aware that in the context of gender-affirming care, some courts have permitted Section 1557 claims to proceed past the pleadings stage absent an ERISA claim for benefits. *See, e.g.*, *Scott v. St. Louis Univ. Hosp.,* 600 F. Supp. 3d 956, 960 (E.D. Mo. 2022); *Toomey v. Arizona*, 2019 WL 7172144, at *3 (D. Ariz. Dec. 23, 2019). But these cases are distinguishable because the health plans there contained blanket exclusions on gender-affirming care and, accordingly, the plaintiffs were "not seeking to recover on the Plan." *Toomey*, 2019 WL 7172144, at *3[16]; *Scott*, 600 F. Supp. 3d at 960 (noting plaintiff was not "seeking to enforce her rights under an ERISA plan" because "the Plan expressly excludes coverage for sex transition . . . ."). Here, by contrast, Plaintiff is seeking to recover benefits that she alleges are covered by the Plan. *See* Compl. ¶ 7 ("Class Members suffer the indignity of being told they are denied authorization for treatments covered by their plans…"); ¶ 72 ("Mara will be denied coverage again when she attempts to have a second child . . ."). [17] To the extent that Plaintiff's claim is that she has been denied benefits covered by her Plan, it is an ERISA claim for benefits and should be vindicated through a claim brought under ERISA § 502(a)(1)(B).

IV. AETNA INC. SHOULD BE DISMISSED BECAUSE IT IS A HOLDING COMPANY THAT DOES NOT PROVIDE HEALTH INSURANCE.

Aetna Inc. is a holding company that has no insurance operations or products, is not licensed to sell insurance, and has no role in the administration of Aetna health insurance plans. Allocca Decl. ¶¶ 4, 10-12. The Plan documents and MSA between Encore and Aetna make clear that Encore is the Plan administrator and Plan fiduciary. MSA at 8-9; *id.* Ex. B. Aetna Inc. has no involvement with the daily insurance operations of Aetna Life Insurance Company and had no responsibility for or involvement with operations of the Encore Plan or the services provided by Encore as Plan Administrator. Allocca Decl. ¶¶ 6, 12.

Plaintiff's Complaint makes no allegations against Aetna Inc. except to say that Aetna Life Insurance Company is its wholly-owned subsidiary. Compl. ¶ 15. Plaintiff does not allege

[16] *Toomey* involved a non-ERISA plan.

[17] Plaintiff's assertion that she will be denied coverage when she attempts to conceive again is facially speculative, insofar as health benefits plans may make changes to their terms year-over-year, and Plaintiff simply assumes Encore's plan terms will remain the same.

that Aetna Inc. had anything at all to do with the Encore Plan. That Aetna Inc. is a parent company of Aetna Life Insurance Company does not, by itself, make Aetna Inc. a proper party to this action. "It is a general principle of corporate law deeply ingrained in our economic and legal systems that a parent corporation (so-called because of control through ownership of another corporation's stock) is not liable for the acts of its subsidiaries." *Biggins v. Wells Fargo & Co.*, 266 F.R.D. 399, 413-14 (N.D. Cal. 2009) (citation and internal quotations omitted).

Aetna Inc. is not a proper party and should be dismissed pursuant to Rule 12(b)(6).

CONCLUSION

For the reasons stated herein, Aetna respectfully requests that the Court grant this Motion and dismiss Plaintiff's Complaint in its entirety.

Respectfully submitted,

Dated: July 24, 2023

O'MELVENY & MYERS LLP

/s/ Susannah K. Howard

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARA BERTON, on behalf of herself and all others similarly situated,

Plaintiff,

v.

AETNA INC. and AETNA LIFE INSURANCE COMPANY,

Defendants.

Case No. 4:23-cv-01849-HSG

DECLARATION OF CRAIG ALLOCCA IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS COMPLAINT

Hearing Date: October 12, 2023
Time: 2:00 p.m.
Location: Ronald V. Dellums Federal Building, 1301 Clay Street, Oakland, CA 94612 Courtroom 2, 4th Floor

DECLARATION OF CRAIG ALLOCCA

I, Craig Allocca, hereby declare as follows:

1. I am over the age of 21 and have personal knowledge of the facts set forth herein. The following facts arose during the course of my duties working on behalf of Aetna Life Insurance Company, which is a corporate subsidiary of Aetna Inc. I am authorized and qualified to speak on behalf of Aetna Inc. and Aetna Life Insurance Company with respect to the matters herein. If called and sworn as a witness, I could and would testify truthfully as to the matters stated herein.

2. I have been employed by Aetna affiliates for 32 years. I am currently employed by Aetna Resources LLC as Director of Treasury Services. My job responsibilities include, among other things, knowledge of the Aetna companies and their corporate structure.

3. Aetna Inc. is a Pennsylvania corporation.

4. Aetna Inc. is a holding company that has no insurance operations or products.

5. Aetna Life Insurance Company ("ALIC") is a corporation formed under the laws of Connecticut that provides and administers certain Aetna health insurance plans.

6. ALIC is the entity that administered the relevant plan at issue in this case, the Choice POS II – Premier PPO Plan (the "Encore Plan"). Aetna Inc. had no responsibility for or involvement with the Encore Plan's operations or the services performed by ALIC as Claims Administrator for that Plan.

7. ALIC is owned in its entirety by Aetna Inc.

8. Aetna Inc. and ALIC maintain separate books and bank accounts.

9. Aetna Inc. and ALIC have separate officers.

10. Aetna Inc. is not licensed to sell insurance in any state.

11. Aetna Inc. has no insurance operations or products.

12. Aetna Inc. has no involvement with the daily insurance operations of ALIC or with the provision or administration of health insurance plans.

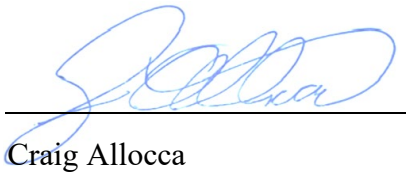
13. Aetna Inc. has no employees.

14. I am authorized by ALIC to make the statements and representations set forth in this

declaration.

Pursuant to 28 U.S.C. § 1746(2), I declare, under penalty of perjury under the laws of the United States of America that the above statements are true and correct to the best of my knowledge, information, and belief.

Executed this 20 th day of July, 2023.
At Hartford, CT



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Aetna Inc. and Aetna Life Insurance Company

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARA BERTON, on behalf of herself and all others similarly situated,

Plaintiff,

v.

AETNA INC. and AETNA LIFE INSURANCE COMPANY,

Defendants.

Case No. 4:23-cv-01849-HSG

DECLARATION OF ROBERT GOLDBECK IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS COMPLAINT

Hearing Date: October 12, 2023
Time: 2:00 p.m.
Location: Ronald V. Dellums Federal Building, 1301 Clay Street, Oakland, CA 94612 Courtroom 2, 4th Floor

DECLARATION OF ROBERT GOLDBECK

I, Robert Goldbeck, hereby declare as follows:

1. I have worked for Aetna Resources LLC, or other affiliates of defendant Aetna Life Insurance Company (collectively, "Aetna") for approximately 24 years. I am currently a Senior Account Executive at Aetna. As a Senior Account Executive, my job duties include knowledge of the Choice POS II – Premier PPO Plan (the "Encore Plan"). In addition, I am familiar with Aetna's business practice and process for maintaining records related to the Encore Plan.

2. This declaration is submitted in support of Aetna's Motion to Dismiss Plaintiff's Complaint and in support of Aetna's Administrative Motion to File Documents Under Seal Pursuant to Civil Local Rules 7-11 and 79-5. I have personal knowledge of the following facts. If called as a witness in this action, I could and would testify competently to these facts.

3. Attached hereto as **Exhibit A** is a true and correct copy of the Master Services Agreement between Encore and Aetna Life Insurance Company ("MSA"), effective January 1, 2022, which Aetna has maintained in its files. The MSA sets forth the terms of Aetna's administrative services agreement with Encore.

4. Aetna treats the MSA as confidential and does not publicly disclose this document, as it contains information that is commercially sensitive to both Aetna and its non-party clients. The terms of the MSA are the product of private contractual negotiations between Aetna and Encore.

5. It would be potentially commercially harmful to Aetna if competitors were able to glean information from this document. Based on our dealings with clients, I believe that non-party Encore similarly has an interest in maintaining the confidentiality vis-à-vis its competitors of the benefit plans it offers to its employees.

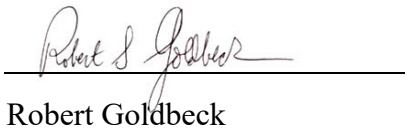
6. Because the MSA as a whole contains confidential information of the above nature, redactions would not be sufficient to protect Aetna's and Encore's interest in maintaining the confidentiality of these documents.

7. Attached hereto as **Exhibit B** is a true and correct copy of the Encore Plan Summary

Plan Description ("SPD"), effective January 1, 2022, which Aetna has maintained in its files. The SPD sets forth health benefit plan terms that Encore has selected for plan participants and beneficiaries.

Pursuant to 28 U.S.C. § 1746(2), I declare, under penalty of perjury under the laws of the United States of America that the above statements are true and correct to the best of my knowledge, information, and belief.

Executed this 21st day of July, 2023.
At Parsippany in the State of New Jersey



Robert Goldbeck

EXHIBIT A

EXHIBIT FILED UNDER SEAL

EXHIBIT B

Choice POS II medical plan - Premier PPO Plan

Booklet

Prepared for:

Employer:	Encore Group USA LLC.
Contract number:	MSA-0109216
Plan name:	Choice POS II - Premier PPO Plan
Booklet:	5
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Third Party Administrative Services provided by
Aetna Life Insurance Company

Table of contents

Welcome

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

Welcome to Aetna.

Introduction

This is your booklet. It describes your **covered services** – what they are and how to get them. It also describes how we manage the plan, according to our policies, and applicable laws and regulations. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Together, these documents describe the benefits covered by your Employer's self-funded health benefit. Each may have amendments attached to them. These change or add to the document. This booklet takes the place of any others sent to you before.

It's really important that you read the entire booklet and your schedule of benefits.

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

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

How we use words

When we use:

- "You" and "your" we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our", we mean Aetna Life Insurance Company (Aetna)
- Words that are in bold, these are defined in the *Glossary* section

Contact us

Your plan includes the Aetna concierge program. It provides immediate access to consultants trained in the specific details of your plan.

For questions about your plan, you can contact us by:

- Calling the toll-free number on your ID card
- Writing us at 151 Farmington Ave, Hartford, CT 06156
- Visiting https://www.aetna.com to access your member website

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

Your ID card

Show your ID card each time you get **covered services** from a **provider**. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary one using your member website.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, or categories of healthcare **providers**, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment**, **deductible** or **payment percentage** amounts
- Contributions to a health savings account
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible; but, we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Coverage and exclusions

Providing covered services

Your plan provides **covered services**. These are:

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

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

For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- Your **provider** may recommend services that are considered **experimental or investigational** services. But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us. You can find out about limitations for **covered services** in the schedule of benefits.

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency Ground Ambulance

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency Ground Ambulance

Covered services also include precertified transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

> **Important note:**
> Applied behavior analysis may require **precertification** by us. See the *How your plan works – Medical necessity and precertification* section.

Autism spectrum disorder

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

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Behavioral health

Mental health disorders treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound

        - Your **physician** orders them
        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
        - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - Observation
    - Peer counseling support by a peer support specialist

Substance related disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **substance related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist

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

Clinical trials

Routine patient costs

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

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers. But, there are some DME items Medicare covers that your plan does not.

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

Covered services also include:

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

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Your coverage for **emergency services** will continue until your condition is stabilized and:

- Your attending **physician** determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another **provider** if you need more care
- You are in a condition to be able to receive from the **out-of-network provider** delivering services the notice and consent criteria with respect to the services
- Your **out-of-network provider** delivering the services meets the notice and consent criteria with respect to the services

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

Non-emergency services
If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

Foot orthotic devices

Covered services include a mechanical device, ordered by your **physician**, to support or brace weak or ineffective joints or muscles of the foot.

Gender affirming treatment

Covered services include certain services and supplies for gender affirming (sometimes called sex change) treatment.

Important note:
Just log into your **Aetna** website at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this **covered benefit,** including eligibility and medical necessity requirements. You can also call *Member Services* at the telephone number on the back of your I.D. card.

Habilitation therapy services

Habilitation therapy services help you keep, learn or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

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

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development

(Speech function is the ability to express thoughts, speak words and form sentences)

The following are not **covered services**:

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

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

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

Home health care

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

- You are homebound
- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

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

The following are not **covered services**:

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

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

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

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

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

The following are not **covered services**:

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

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider:**

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

Comprehensive infertility services

Covered services include the following **infertility** services provided by an **infertility specialist**:

- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination

Infertility covered services may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, 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
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's i**nfertility** clinical policy

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.

The following are not **covered services**:

- All **infertility** services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.
- 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.
- 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.
- Treatment for dependent children.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Institutes of Quality

Aetna Institutes of Quality (IOQ) program is a network of facilities/clinics of publicly recognized, high-quality, high-value health care providers. These providers offer access to a quality and efficient network for specific procedures. The Institutes have met extensive quality, as well as cost-effectiveness criteria. The Institutes of Quality program applies to adult members (age 18 and over) only.

The IOQs are Aetna facilities participating under standard Aetna contracts and are *designated* through a targeted Request For Information (RFI) process. Designation is valid for two years provided that the facility maintains compliance with the IOQ program requirements.

Institutes of Quality Bariatric

Bariatric surgery, also known as weight loss surgery, refers to the various surgical procedures performed to treat people living with morbid or extreme obesity. It is an effective treatment for weight loss for those who have not experienced long-term weight loss success through other means.
Bariatric IOQ facilities provide the following services:

- Lap bands - device wrapped around upper part of stomach to make it smaller for less food intake
- Bypass - creation of a small pouch in stomach that is connected pouch directly to middle part of small intestine, bypassing the remainder of stomach and upper small intestine
- Sleeve gastrectomy - removal of majority of stomach creating narrow tube to decrease amount of food eaten and decrease amount of food absorbed

Institutes of Quality Cardiac Care

Institutes of Quality Cardiac Care facilities is a network of providers that have met Aetna's requirements for clinical quality, value and access for cardiac care. Aetna worked with heart experts and professional groups to create our quality network requirements. These groups include the American College of Cardiology (ACC) and the Society for Thoracic Surgeons (STS).
Cardiac IOQ facilities provide the following services:

- Rhythm
    - Pacemakers - small battery-powered device that sends weak electrical impulses to enable heart to keep a regular heartbeat
    - Defibrillator - small battery-powered device used to treat an abnormal heart rhythm or rate
- Interventional
    - Heart Cath - procedure performed to show blood flow through heart chambers and arteries
    - PTCA - balloon opening artery of heart
    - Stent - small expandable tube used to keep an artery open to increase blood flow
- Surgery
    - CABG, Valve w/ CABG, Valve w/out CABG - repairing or replacing the damaged flaps inside the heart to allow blood to flow more easily and in the right direction

Institutes of Quality Orthopedic Care

Institutes of Quality Orthopedic Care is a network of providers that have met Aetna's requirements for clinical quality, value and access for orthopedic care. The procedure evaluation is limited to knee replacement, hip replacement, and spine surgery. Facilities must meet all requirements for knee and hip replacement to be designated for either, while spine surgery designation may be a stand-alone designation. A facility may also be designated for all three disciplines if all program requirements are met.

Aetna Orthopedic IOQs provide a full range of orthopedic care services. These include:

- Spine
    - Primary Fusion - surgery to join or fuse two or more vertebrae together
    - Fusion Revision - surgery done when the first operation to fuse the vertebrae does not work

  - Discectomy (w/out decompression) - removal of protruding disc material that is pressing on a nerve or the spinal cord
  - Decompression (w/out fusion) - removal of bony growths or parts of vertebrae to enlarge spinal canal to relieve pressure on nerve roots
- Total Joint Replacement
  - Knee Replacement - replacement of both damaged bone ends of the joint and knee cap with artificial material
  - Hip Replacement - replacement of the damaged joint with an implant

Jaw joint disorder treatment

Covered services include the diagnosis, surgical treatment and limited non-surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following are not **covered services**:

- Non-surgical medical and dental services, and therapeutic services related to **jaw joint disorder**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 1 home visits after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, a dentist and **hospital**:

- Cutting out:
  - Teeth partly or completely impacted in the bone of the jaw
  - Teeth that will not erupt through the gum
  - Other teeth that cannot be removed without cutting into bone
  - The roots of a tooth without removing the entire tooth
  - Cysts, tumors, or other diseased tissues.
- Cutting into gums and tissues of the mouth
  - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

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

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

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Physician services

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

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

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

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

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

For frequencies and limits, contact your **physician** or us. This information is also available at https://www.healthcare.gov/.

Important note:
Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support **provider**.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

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

Counseling services

Covered services include preventive screening and counseling by your **health professional** for:

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a **physician** during an office visit.
- Voluntary sterilization including 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.

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Contraceptives (birth control)

For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from you **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

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

The following is not a **covered service**:
Brand-name prescription drug forms of contraception in each of the methods identified by the FDA

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

Preventive care drugs

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA, when you have a **prescription** and it is filled at a network pharmacy.

Risk reducing breast cancer prescription drugs

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

Tobacco cessation prescription and OTC drugs
Covered services include FDA-approved drugs and OTC aids, drugs to help stop the use of tobacco products, including nicotine replacement therapy. All OTC aids must be prescribed by a **provider**.

Routine cancer screenings

Covered services include the following routine cancer screenings:

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

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

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

Private duty nursing - outpatient

Covered services include private duty nursing care provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

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

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

Coverage includes:

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

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or **surgery** to sound natural teeth injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital**, **skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

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

Covered services include:

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

Cognitive rehabilitation, physical, occupational, and speech therapy
Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

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

The following are not **covered services**:

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

Skilled nursing facility

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

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

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**:

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

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a **physician**, **hospital** or other **provider**.

Key Terms

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

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:
You must get GCIT **covered services** from the GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

Infusion therapy

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Covered services also include:

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

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this booklet and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket**, and limits, unless stated differently in this booklet and schedule of benefits

Important note:
If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

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

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening emergency medical condition. An "urgent care center" is a facility licensed as a freestanding medical facility to treat urgent conditions.

Covered services include services and supplies to treat an urgent condition as described below:

- Urgent condition within the network (in-network)
  - If you need care for an urgent condition, you should first seek care through your **physician**, **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- Urgent condition outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and the service can't be delayed.

If you go to an urgent care center for what is not an urgent condition, the plan may not cover your expenses. See the schedule of benefits for more information.

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Vision care services and supplies

Covered vision services and supplies include those prescribed for the first time and those required because of a change in **prescription:**

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses that are identified by a **vision provider**
- Aphakic lenses prescribed after cataract surgery

The following are not **covered services and supplies**:

Special supplies such as non-**prescription** sunglasses

- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a **hospital** or other facility for health care
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Walk-in clinic

Covered services include, but are not limited to, health care services provided through a **walk-in clinic** for:

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

General plan exclusions

The following are not **covered services** under your plan:

Behavioral health treatment

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section
- Pathological gambling, kleptomania, and pyromania

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

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Coverage and exclusions*, *Transplant services* section

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Coverage and exclusions* section

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **payment percentage**, **deductible**, or any other amount

Court-ordered services and supplies

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

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials.

Foot care

Routine services and supplies for the following:

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

Gene-based, cellular and other innovative therapies (GCIT)

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include:
  - Infusion
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

See the *How your plan works – Medical necessity and precertification requirements* section.

Growth/height care

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

Hearing aids

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Medical foods
- Other nutritional items

Obesity surgery and services

Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Coverage and exclusions* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
- **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other non-covered services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Prescription or non-prescription drugs and medicines - outpatient

- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section.

Routine exams and preventive services and supplies

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery**, **prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Telemedicine

Consultations or services provided by a **physician**, **specialist**, or **telemedicine provide**r by means of electronic communication.

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the *Covered services and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services and exclusions* section
- Nicotine patches
- Gum

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

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

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

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

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your plan works

How your medical plan works while you are covered in-network

Your in-network coverage helps you get and pay for a lot of, but not all, health care services. Your cost share is lower when you use a **network provider**.

Providers

Our **provider** network is there to give you the care you need. You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online provider directory. See the *Contact us* section for more information.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**. Your plan may pay a bigger share for **covered services** you get through your **PCP**, so choose a **PCP** as soon as you can.

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

How your medical plan works while you are covered out-of-network

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network and from **network providers** without a **PCP referral**
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Who provides the care

Network providers

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

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

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

Your PCP

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

How you choose your PCP

You can choose a **PCP** from the list of **PCP**s in our directory.

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

What your PCP will do for you

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

Changing your PCP

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

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **recognized charge**
- Submitting your own claims and getting **precertification**

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

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

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

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

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

Medical necessity and precertification requirements

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

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

Medically necessary, medical necessity

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

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

Precertification

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

In-network

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

Out-of-network

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

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

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

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

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

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

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

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

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

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies.

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

Inpatient services and supplies	Outpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavior analysis
Gender affirming treatment	ART services
Obesity (bariatric) **surgery**	Complex imaging
Stays in a **hospice** facility	Comprehensive **infertility** services
Stays in a **hospital**	**Cosmetic** and reconstructive **surgery**
Stays in a **rehabilitation facility**	Emergency transportation by airplane
Stays in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**	Gene-based, cellular and other innovative therapies (GCIT)
Stays in a **skilled nursing facility**	Gender affirming treatment
	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	Kidney dialysis
	Knee **surgery**
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental health disorders** and **substance related disorders** treatment
	Private duty nursing services
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

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

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

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

What the plan pays and what you pay

Who pays for your **covered services** – this plan, both of us, or just you? That depends.

The general rule

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

- You pay the **deductible**, when it applies.
- Then the plan and you share the expense. Your share is called a **copayment** or payment percentage.
- Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**, and **recognized charge** for an **out-of-network provider**.

Negotiated charge

For health coverage:

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

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

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

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. Through NAP, the **recognized charge** is determined as follows:

- If your service was received from a NAP **provider**, a pre-negotiated charge will be paid**.** NAP **providers** are **out-of-network providers** that have contracts with Aetna, directly or through third-party vendors, that include a pre-**negotiated charge** for services. NAP **providers** are not **network providers**.
- If your service was not received from a NAP **provider,** a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the **recognized charge** for specific services or supplies will be the **out-of-network plan rate**, calculated in accordance with the following:

Service or Supply	**Out-of-Network Plan Rate**
Professional services	100% of the Medicare allowable rate
Inpatient and outpatient charges of **hospitals**	100% of the Medicare allowable rate
Inpatient and outpatient charges of facilities other than **hospitals**	

Important note: If the **provider** bills less than the amount calculated using the **out-of-network plan rate** described above, the **recognized charge** is what the **provider** bills.

If NAP does not apply to you, the **recognized charge** for specific services or supplies will be the out-of-network plan rate set forth in the above chart.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain **out-of-network providers**
- Not available from a **network provider**
- **Emergency services**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note:
In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services,** you will pay the same cost share you would have if the **covered services** were received from a **network provider.** The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

Special terms used

- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
  - For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.

- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help you decide where to get care. Use the "Estimate the Cost of Care" tool on Aetna member website. **Aetna's** secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-**network** coverage, they are:

- The service is **medically necessary**
- You get your care from a **network provider**
- You or your **provider** precertifies the service when required

For **out-of-network** coverage:

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

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

You pay the entire expense when:

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

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

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive **covered services** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply.

Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like **deductibles**, **copayments** and **payment percentage**.

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

Coordination of benefits

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

Key Terms

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

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

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

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

How COB works

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

Determining who pays

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

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

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

How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare, even if you are not covered, if you refused it, dropped it, or didn't make a request for it.

Effect of prior plan coverage

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

Your current and prior plan must be offered through the same policyholder.

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Benefit payments and claims

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

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

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

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

Concurrent care claim extension
A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

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

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

Filing a claim
When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

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

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

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

Complaints, claim decisions and appeals procedures

The difference between a complaint and an appeal

A Complaint

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

An Appeal

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

Claim decisions and appeal procedures

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

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

Appeals of adverse benefit determinations

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

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

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

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

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

Urgent care or pre-service claim appeals
If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having you fill out an authorized representative form telling us that you are allowing the provider to appeal for you.

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

Timeframes for deciding appeals

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

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

Exhaustion of appeals process

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

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

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

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

External review

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

You have a right to external review only if:

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

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

You must submit the Request for External Review Form:

- To **Aetna**
- Within 123 calendar days (four months) of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

Aetna will:

- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information.

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

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

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

There are two scenarios when you may be able to get a faster external review:
For initial adverse determinations
Your **provider** tells us that a delay in your receiving health care services would:

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

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

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

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

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

Your employer decides and tells us who is eligible for health coverage.

When you can join the plan

You can enroll:

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

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

If you don't enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Dependent children – yours or your spouse's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody

Adding new dependents

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

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

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

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

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

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state fee assistance under Medicaid or S-CHIP which will pay your fee contribution under this plan

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

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

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

Stopping coverage

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

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

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- Your employer asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making fee contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

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

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

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

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet

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

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Your coverage is defined by the group contract. This document may have amendments and riders too. Under certain circumstances, we, the Customer/Employer or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the Customer/Employer or **provider**, can do this.

Physical examination and evaluations

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

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an appeal
- You have the right to a third party review conducted by an independent ERO

Some other money issues

Legal action

You must complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions, and, appeal procedures* section.
You cannot take any action until 60 days after we receive written submission of a claim.

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

Assignment of benefits

When you see a **network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. To the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Financial sanctions exclusions

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

Recovery of overpayments

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

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

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

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

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

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

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

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

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

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

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

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

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

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

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

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

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

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

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

Sutter Health and Affiliates Services

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

Glossary

Behavioral health provider

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

Brand-name prescription drug

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

Copay, copayment

Copays are flat fees for certain visits. A **copay** can be a dollar amount or percentage.

Covered service

The benefits, subject to varying cost shares, covered under the plan. These are:

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

Deductible

A **deductible** is the amount you pay out-of-pocket for **covered services** per year before we start to pay.

Detoxification

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

Drug guide

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

Emergency medical condition

A severe medical condition that:

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

Emergency services

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

Experimental or investigational

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

A drug, device, procedure, or treatment is **experimental or investigational** if:

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

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

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

Home health care agency

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

Hospital

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

Infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

- For an individual or their partner who has been clinically diagnosed with gender identity disorder.

Institutes of Quality® (IOQ) (Bariatric, Orthopedic and Cardiac)

A national network of facilities publicly recognized, high-quality, high-value health care providers. These providers offer access to a quality and efficient network for specific procedures. The Institutes have met extensive quality, as well as efficiency criteria.

Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme, obesity. IOQ Bariatric Surgery procedures include: gastric bypass, adjustable gastric band and sleeve method
IOQ Cardiac Care services include Cardiac Medical Intervention, Heart Surgery and Heart Rhythm Disorders.
IOQ Orthopedic Care services include Spine Surgeries and Total Joint Replacement.

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most a covered person will pay per year in **copayments**, **contribution** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

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

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

Generally accepted standards of medical practice mean:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

Mental health disorder

A **mental health disorder** is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental health disorder** is in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association*.

Negotiated charge

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

Network provider
A **provider** listed in the directory for your plan. A NAP **provider** listed in the NAP directory is not a **network provider**.

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

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

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

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

Primary care physician (PCP)
A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

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

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

Recognized charge
See *How your plan works – What the plan pays and what you pay*.

Residential treatment facility

An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance related disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:
For residential treatment programs treating **mental health disorders**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For substance related residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs.

Room and board

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

Semi-private room rate

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

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care. **Skilled nursing facilities** also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

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

Specialist

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

Stay

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

Substance related disorder

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

Surgery, surgical procedure

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telemedicine

A consultation between you and a **physician**, **specialist**, or **telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

Terminal illness

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

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- Physician's office
- Urgent care facility

Additional Information Provided by

Encore Group USA LLC.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan:
Choice POS II

Employer Identification Number:
13-4025666

Plan Number:
Refer to your Plan Administrator for this information

Type of Plan:
Welfare

Type of Administration:
Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Encore Group USA LLC.
5100 N. River Road Suite 300
Schiller Park, IL 60176
Telephone Number: (847) 462-7040

Agent For Service of Legal Process:
Encore Group USA LLC.
5100 N. River Road Suite 300
Schiller Park, IL 60176

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

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

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

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Attorneys for Defendants
Aetna Inc. and Aetna Life Insurance Company

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARA BERTON, on behalf of herself and all others similarly situated,

Plaintiff,

v.

AETNA INC. and AETNA LIFE INSURANCE COMPANY,

Defendants.

Case No. 4:23-cv-01849-HSG

DECLARATION OF DONNA LYNCH IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS COMPLAINT

Hearing Date: October 12, 2023
Time: 2:00 p.m.
Location: Ronald V. Dellums Federal Building, 1301 Clay Street, Oakland, CA 94612 Courtroom 2, 4th Floor

DECLARATION OF DONNA LYNCH

I, Donna Lynch, hereby declare as follows:

1. I am over the age of 21 and have personal knowledge of the facts set forth herein. I am employed by Aetna Resources, LLC, and have worked for Aetna Life Insurance Company, or other affiliates of defendant Aetna Life Insurance Company (collectively, "Aetna") for approximately 27 years. I am currently a Senior Analyst of Project Management at Aetna's Legal Department.

2. As a Senior Analyst of Project Management, my job duties include managing a team of individuals who pull Aetna documents relating to pending legal matters. I am familiar with Aetna's business practice and process for maintaining and retrieving records and communications that are sent to members and healthcare providers.

3. This declaration is submitted in support of Aetna's motion to dismiss plaintiff's complaint. I have personal knowledge of the following facts. If called as a witness in this action, I could and would testify competently to these facts.

4. Attached hereto as **Exhibit A** is a true and correct copy of a letter dated February 21, 2022, sent by Aetna to Ms. Berton.

5. Attached hereto as **Exhibit B** is a true and correct copy of a letter dated June 11, 2022, sent by Ms. Berton to Aetna.

6. Attached hereto as **Exhibit C** is a true and correct copy of a letter dated June 30, 2022, sent by Aetna to Ms. Berton.

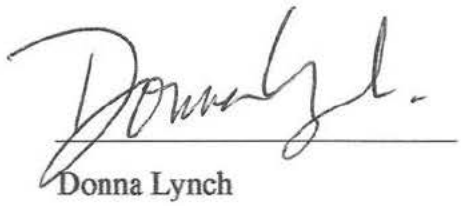
7. Attached hereto as **Exhibit D** is a true and correct copy of a letter dated August 7, 2022, sent by Ms. Berton to Aetna.

8. Attached hereto as **Exhibit E** is a true and correct copy of a letter dated September 5, 2022, sent by Aetna to Ms. Berton.

9. Attached hereto as **Exhibit F** is a true and correct copy of the case summary for Ms. Berton's appeal, pulled on April 17, 2023.

Pursuant to 28 U.S.C. § 1746(2), I declare under penalty of perjury under the laws of the United States of America that the above statements are true and correct to the best of my knowledge, information, and belief.

Executed this 14th day of July, 2023.
At King of Prussia, Pennsylvania



Donna Lynch

EXHIBIT A

Aetna Life Insurance Company
PO Box 14876
Lexington KY 40512-4876
*002188*J1VCEX33*010368*

MARA G BERTON
[redacted]

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Aetna Life Insurance Company
PO Box 14876
Lexington KY 40512-4876

MARA G BERTON
[redacted]

Feb 21 2022

Member Name: MARA G BERTON
Member ID: [redacted]
Date of Birth: [redacted]
Case Number: 8718520210000000
Plan Sponsor: ENCORE GROUP USA LLC.
Plan Sponsor Account Number: 109216-13-002-M

Dear Member and Healthcare Provider(s) of Record

After review, we have made a decision about coverage for the following health care services for the member named above. We use nationally recognized clinical guidelines and resources, such as MCG criteria and Clinical Policy Bulletins available at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html, applicable state guidelines when required, and benefit plan documents to support these coverage decisions.

Coverage Decisions For Denied Services:
Provider(s): [redacted]

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
02/08/2022 - 02/08/2023	58322	[redacted]	[redacted]	Time(s)

Coverage for this service has been denied for the following reason(s):

We are denying coverage for the requested service because the member does not meet the plan definition of infertility. Per the plan, infertility is defined as [redacted]

(Infertility Benefit Denial) This coverage denial was based on the terms of the member's benefit plan document (such as the Certificate of Coverage or benefit plan booklet/handbook, including any amendments or riders). The plan limits coverage for infertility treatment. Please see the reference to infertility treatment listed in the Exclusions section of the benefit plan document or refer to the description of infertility benefits in the section of the plan document that talks about what the plan covers.

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Information About Coverage Denials: "Coverage" means whether or not a service or treatment is covered under the terms of the member's benefit plan or payable under the terms of the provider's agreement.

Our decision is limited to whether the health care services are covered under the member's benefit plan or provider agreement. The treating practitioner, in consultation with the member, remains responsible for deciding what treatment is appropriate and what services to provide.

Denial codes are not used and therefore not available.

Member Appeal Rights: You may not agree with our decision. You or someone you choose to act for you (called your authorized representative) can ask us for a review (appeal). Do this by phone or in writing within 180 days (6 months) after you receive this letter. Some plans give more than 180 days to do this. See your plan brochure or other plan document, such as your Certificate of Coverage or your Summary Plan Description.

How to ask for an appeal by phone

Call Member Services. The toll-free telephone number is listed on your member ID card. If you are hearing impaired you can call 711 for Telecommunication Relay Services (TRS). Member Services can also help you with the process of naming an authorized representative.

How to ask for an appeal in writing

You or your authorized representative can send a letter or a completed Member Complaint and Appeal Form to the address below. The form is online at: https://member.aetna.com/memberSecure/assets/pdfs/forms/68192.pdf.

Aetna
National Accounts CRT
P.O. Box 14001
Lexington KY 40512

Your request should include:

- Your name;
- Your member ID number (or date of birth) or other identifying information;
- The group s name (for example, if you are covered by your employer);
- Comments, documents, records and other information you want us to consider.

You may also ask us for documents that are relevant to the unfavorable decision for your review. These are free. Call Member Services to ask for them. The toll-free telephone number is listed on your member ID card.

In general, one level of internal appeal is available under health plans providing coverage for individuals, and two levels of internal appeal are available under plans covering employees of an employer.

ONE LEVEL APPEAL PROCESS:
If your plan offers a single appeal and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 30 days after we

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receive your request. For post-service appeal requests, we will send you a decision within 60 days after we receive your request.

If your appeal is urgent (one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain), you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 72 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

TWO LEVEL APPEAL PROCESS:
If your plan provides for two appeals and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 15 days after we receive your request.

For post-service appeal requests, we will send you a decision within 30 days after we receive your request. In either case, if you do not agree with the decision you have the right to file a second request for appeal. To do this, call or write to us within 60 days from the date that you receive the first appeal decision.

If your appeal is urgent (one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain), you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 36 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

After your appeal, if we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review by an independent third party, who will review our decision and make a final decision. Contact your employer or refer to your plan documents for additional instruction on external review.

If you do not agree with the final decision you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

We Protect Your Privacy:
Protecting the privacy of member health information is a top priority. When contacting us about this Notice or for help with other questions, please be prepared to provide member name, member ID number, and date of birth.

Patient Safety Information:
To learn more about patient safety and hospitals, please log on to The Leapfrog Group's website at http://www.leapfroggroup.org/. This site will give you information about hospitals that have met specific safety standards. For participating hospitals, the same information can be accessed on your secure member website using the provider search.

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Your provider may have sent diagnosis codes with your request for authorization of services. If you wish to obtain these codes and their descriptions, call us at the Member Services number on your medical identification card. If you have medical questions about your diagnosis, contact your provider.

If you suspect fraud or abuse involving your health benefits, please call the toll free Hotline at 1-800-338-6361 or contact us by E-Mail at AetnaSIU@Aetna.com.

Member Services: If you, your authorized representative or your health care providers need help with filing an appeal or complaint or would like additional information about this decision, call the toll-free Member Services number on the member's identification card.

We hope this information has answered your coverage questions. Member Services representatives are available to help health care professionals, members and their authorized representatives with any questions about eligibility, plan benefits, claims and coverage decisions. If you, your authorized representative or your health care providers of record have additional questions or would like to request copies of documents related to the coverage decision, call the toll-free Member Services number on your member ID card.

Need help understanding this notice or our decision? Call us free of charge at the 1-800 number on your medical ID card. There are also other resources available to help you. Most plans are now subject to health care reform law. Call us or ask your employer if your plan is subject to the law. If it is, you can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) for help, if your health plan is provided by your employer. In addition, a consumer assistance program may be available to assist you.

Aetna

A copy of this letter is also being sent to:
[redacted]

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Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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TTY: 711

This Notice has Important Information. You may need to take action by certain dates to keep your health coverage or help with costs. For help in your language at no cost, you can call the number on your ID card. (English)

Este aviso contiene información importante. Es posible que deba realizar determinadas acciones en ciertas fechas para mantener su cobertura de salud u obtener ayuda para pagar los costos. Para obtener ayuda en español sin cargo alguno, llame al número que figura en su tarjeta de identificación. (Spanish)

本通知包含重要資訊。您可能需要在特定日期前採取行動，以保留您的健康承保或關於費用的協助。如欲免費取得中文幫助，您可撥打您保險卡上的電話號碼。(Chinese)

Ang Abisong ito ay Naglalaman ng Mahalagang Impormasyon. Maaaring kailanganin mong gumawa ng aksyon sa tiyak na mga petsa upang mapanatili ang pagsakop sa iyong kalusugan o tulong na may gastos. Para sa tulong sa Tagalog na walang gastos, maaari kang tumawag sa numero sa iyong ID card. (Tagalog)

حتوي هذا الإشعار على معلومات مهمة. لذا يجب أن تتخذ الإجراءات اللازمة في المواعيد المحددة للحفاظ على تغطيتك الصحية أو للحصول على مساعدة في التكاليف. ولتلقي المساعدة بـ (اللغة العربية) مجاناً، يمكنك الاتصال على الرقم الموجود في بطاقة الهوية. (Arabic)

Այս ծանուցում ունի կարեւոր տեղեկություններ. Դուք կարող եք անհրաժեշտ է միջոցներ ձեռնարկել, ըստ որոշ ժամկետների պահել ձեր առողջության լուսաբանումը, կամ օգնել, ծախսերը. Օգնության համար (հայերեն) ոչ մի գնով, դուք կարող եք զանգահարել է մի շարք ձեզ վրա ID քարտ. (Armenian)

इस नोटिस में ज़रूरी जानकारी है। आपको अपनी स्वास्थ्य कवरेज को बनाये रखने या लागतों में सहायता के लिए कुछ विशिष्ट तारीखों तक कार्रवाई करनी पड़ सकती है। बिना किसी लागत के (हिन्दी) में सहायता के लिए, आप अपने आईडी कार्ड पर दिये नम्बर पर कॉल कर सकते हैं।(Hindi)

Daim ntawv ceeb toom no muaj lus qhia tseem ceeb. Koj yuav tsum tau ua qee yam ua ntej cov sib hawm teev tseg kom koj txoj kev pab kho mob dawb los yog kev pab kho mob them nqi qis muaj txuas mus ntxiv. Yog xav tau kev pab hais koj hom lus (Hmoob) pub dawb, koj hu tau rau tus xov tooj ntawm koj daim npav. (Hmong)

本通知は大切なお知らせです。健康保険を保持するため、もしくは費用を抑えるために一定期日までに措置を講じなければならない場合があります。無料にて日本語でお問い合わせになりたい場合は ID カードに記載されている番号までお電話ください。(Japanese)

본 통지서에는 중요한 정보가 담겨져 있습니다. 건강 보험을 계속 유지하거나 비용 관련 도움을 계속해 받으시려면 특정 일자까지 조치를 취하셔야 할 필요가 있습니다. 무료로 한국어로 도움을 받고 싶으시면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

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សេចក្តីជូនដំណឹងនេះ មានព័ត៌មានសំខាន់ៗ។ អ្នកអាចត្រូវធ្វើសកម្មភាព ត្រឹមកាលបរិច្ឆេទជាក់លាក់ ដើម្បីទទួលបានការរ៉ាប់រងលើចំណាយផ្នែកសុខភាព ឬ ជំនួយសម្រាប់ចំណាយនានា។ សម្រាប់ជំនួយជាភាសាខ្មែរ ដោយឥតគិតថ្លៃ អ្នកអាចទាក់ទងលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ (Mon-Khmer, Cambodian)

ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਦਿੱਤੀ ਗਈ ਹੈ। ਆਪਣੀ ਸਿਹਤ ਕਵਰੇਜ਼ ਨੂੰ ਬਣਾਏ ਰੱਖਣ ਲਈ ਜਾਂ ਲਾਗਤਾਂ ਵਿੱਚ ਮਦਦ ਲਈ ਤੁਹਾਨੂੰ ਕੁਝ ਖਾਸ ਤਾਰੀਖਾਂ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨੀ ਪੈ ਸਕਦੀ ਹੈ। ਬਿਨਾਂ ਲਾਗਤ ਦੇ (ਪੰਜਾਬੀ) ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਲਈ, ਤੁਸੀਂ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। (Panjabi - Punjabi)

این اطلاعیه حاوی اطلاعاتی مهم است. ممکن است که لازم باشد شما برای حفظ بیمه سلامت خود و یا کمک به هزینه های درمانی خود در تاریخ های معینی اقداماتی انجام دهید. برای دریافت کمک به زبان فارسی به صورت مجانی، می توانید با شماره تلفن موجود روی کارت شناسایی خود تماس حاصل کنید.(Persian-Farsi)

В этом Уведомлении содержатся важные сведения. Для того чтобы сохранить страховку или получить помощь в оплате полученных услуг, Вам, возможно, нужно что-то сделать в сроки, указанные в этом уведомлении. Если Вам нужна помощь на русском языке, Вы можете ее бесплатно получить, позвонив по телефону, указанному на Вашей идентификационной карточке участника плана. (Russian)

หนังสือแจ้งนี้มีข้อมูลสำคัญ
คุณอาจต้องดำเนินการภายในวันที่ที่กำหนดเพื่อคงความคุ้มครองด้านสุขภาพหรือความช่วยเหลือเรื่องค่าใช้จ่าย สำหรับความช่วยเหลือเป็น (ภาษาไทย) โดยไม่เสียค่าใช้จ่าย
คุณสามารถโทรไปยังหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ (Thai)

Thông Báo này có Thông Tin quan trọng. Quý vị có thể cần thực hiện vào những ngày nhất định để giữ bảo hiểm của quý vị hoặc được trợ giúp chi phí. Để được trợ giúp bằng tiếng Việt miễn phí, quý vị có thể gọi đến số điện thoại ghi trên thẻ ID của quý vị. (Vietnamese)

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Aetna Life Insurance Company
PO Box 14876
Lexington KY 40512-4876
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[redacted]

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Aetna Life Insurance Company
PO Box 14876
Lexington KY 40512-4876

[redacted]

Feb 21 2022

Member Name: MARA G BERTON
Member ID: [redacted]
Date of Birth: [redacted]
Case Number: 8718520210000000
Plan Sponsor: ENCORE GROUP USA LLC.
Plan Sponsor Account Number: 109216-13-002-M

Dear Member and Healthcare Provider(s) of Record

After review, we have made a decision about coverage for the following health care services for the member named above. We use nationally recognized clinical guidelines and resources, such as MCG criteria and Clinical Policy Bulletins available at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html, applicable state guidelines when required, and benefit plan documents to support these coverage decisions.

Coverage Decisions For Denied Services:
Provider(s): [redacted]

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
02/08/2022 - 02/08/2023	58322	[redacted]	[redacted]	Time(s)

Coverage for this service has been denied for the following reason(s):

We are denying coverage for the requested service because the member does not meet the plan definition of infertility. Per the plan, [redacted]

(Infertility Benefit Denial) This coverage denial was based on the terms of the member's benefit plan document (such as the Certificate of Coverage or benefit plan booklet/handbook, including any amendments or riders). The plan limits coverage for infertility treatment. Please see the reference to infertility treatment listed in the Exclusions section of the benefit plan document or refer to the description of infertility benefits in the section of the plan document that talks about what the plan covers.

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Information About Coverage Denials: "Coverage" means whether or not a service or treatment is covered under the terms of the member's benefit plan or payable under the terms of the provider's agreement.

Our decision is limited to whether the health care services are covered under the member's benefit plan or provider agreement. The treating practitioner, in consultation with the member, remains responsible for deciding what treatment is appropriate and what services to provide.

Denial codes are not used and therefore not available.

Provider Information: Participating Providers: Please be advised that for services encompassed within the scope of your provider services contract, you are prohibited from seeking payment from the member.

Provider Appeal Rights: You may appeal this coverage decision if you disagree. If this is a prospective or concurrent decision for services not yet provided or for ongoing services such as an inpatient stay, any appeal would be considered on behalf of the member. Please see the member appeal rights below. If this is a retrospective decision for services that have been completed, you may appeal within 180 days of your receipt of this denial notice. If you decide to appeal, your appeal should include a copy of this denial notice, an explanation of the treatment rationale, and all supporting documents to be considered, including a copy of any pertinent medical records.

To request an appeal on behalf of the member, follow the member appeal instructions below and clearly state that your appeal is on behalf of the member. If your appeal is not on behalf of the member, send your appeal to the following address: Aetna, Attn: Provider Resolution Team, P.O. Box 14020, Lexington, KY 40512.

Member Appeal Rights: You may not agree with our decision. You or someone you choose to act for you (called your authorized representative) can ask us for a review (appeal). Do this by phone or in writing within 180 days (6 months) after you receive this letter. Some plans give more than 180 days to do this. See your plan brochure or other plan document, such as your Certificate of Coverage or your Summary Plan Description.

How to ask for an appeal by phone

Call Member Services. The toll-free telephone number is listed on your member ID card. If you are hearing impaired you can call 711 for Telecommunication Relay Services (TRS). Member Services can also help you with the process of naming an authorized representative.

How to ask for an appeal in writing

You or your authorized representative can send a letter or a completed Member Complaint and Appeal Form to the address below. The form is online at: https://member.aetna.com/memberSecure/assets/pdfs/forms/68192.pdf.

Aetna
National Accounts CRT
P.O. Box 14001
Lexington KY 40512

Your request should include:

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- Your name;
- Your member ID number (or date of birth) or other identifying information;
- The group s name (for example, if you are covered by your employer);
- Comments, documents, records and other information you want us to consider.

You may also ask us for documents that are relevant to the unfavorable decision for your review. These are free. Call Member Services to ask for them. The toll-free telephone number is listed on your member ID card.

In general, one level of internal appeal is available under health plans providing coverage for individuals, and two levels of internal appeal are available under plans covering employees of an employer.

ONE LEVEL APPEAL PROCESS:
If your plan offers a single appeal and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 30 days after we receive your request. For post-service appeal requests, we will send you a decision within 60 days after we receive your request.

If your appeal is urgent (one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain), you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 72 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

TWO LEVEL APPEAL PROCESS:
If your plan provides for two appeals and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 15 days after we receive your request.

For post-service appeal requests, we will send you a decision within 30 days after we receive your request. In either case, if you do not agree with the decision you have the right to file a second request for appeal. To do this, call or write to us within 60 days from the date that you receive the first appeal decision.

If your appeal is urgent (one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain), you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 36 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

After your appeal, if we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review by an independent third

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party, who will review our decision and make a final decision. Contact your employer or refer to your plan documents for additional instruction on external review.

If you do not agree with the final decision you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

We Protect Your Privacy:
Protecting the privacy of member health information is a top priority. When contacting us about this Notice or for help with other questions, please be prepared to provide member name, member ID number, and date of birth.

Patient Safety Information:
To learn more about patient safety and hospitals, please log on to The Leapfrog Group's website at http://www.leapfroggroup.org/. This site will give you information about hospitals that have met specific safety standards. For participating hospitals, the same information can be accessed on your secure member website using the provider search.

Member Services: If you, your authorized representative or your health care providers need help with filing an appeal or complaint or would like additional information about this decision, call the toll-free Member Services number on the member's identification card.

We hope this information has answered your coverage questions. Member Services representatives are available to help health care professionals, members and their authorized representatives with any questions about eligibility, plan benefits, claims and coverage decisions. If you, your authorized representative or your health care providers of record have additional questions or would like to request copies of documents related to the coverage decision, call the toll-free Member Services number on your member ID card.

Aetna

A copy of this letter is also being sent to:
MARA G BERTON

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EXHIBIT B

Aetna
National Accounts CRT
P.O. Box 14001
Lexington, KY 40512

June 11, 2022

To Whom It May Concern:

My name is Mara Berton, I am 30 years old, and I am enrolled in a health insurance plan administered by Aetna Life Insurance Company. The primary policy holder is my wife, June R. Higginbotham. The member ID Number is [redacted] The plan sponsor is Encore Group USA LLC, and the Plan Sponsor Account Number is 109216-13-002-M. I am writing this appeal with regard to Case Number 8718520210000000.

Beginning in January 2022, I sought infertility treatments from [redacted] an in-network provider. Because I am a woman married to a woman, I need infertility treatments to conceive. My doctor submitted a request to Aetna for pre-approval for [redacted] Soon after, an Aetna representative called me about my request for coverage. The represented did not ask me any questions or gather any information about my situation. I was immediately told that I was denied coverage. Soon after, on February 25th, I received a notice from Aetna officially denying coverage. The notice said that I could not receive coverage because I failed to meet the definition of infertility contained in my plan and in Aetna's national Clinical Policy Bulletin #0327 (CPB), which requires that Aetna plan members who are unable to engage in "1 year of frequent, unprotected heterosexual sexual intercourse" must pay out-of-pocket for 6–12 cycles of donor insemination overseen by a physician *before* Aetna will provide coverage for ART.

I am unable to engage in "frequent, unprotected heterosexual sexual intercourse" because I am a woman married to a woman.

Under federal law, it is unlawful for health insurance companies to discriminate based on sex, including sexual orientation, but Aetna treats cisgender heterosexual individuals differently from individuals in same-sex relationships. Aetna forces those unable to engage in heterosexual sexual intercourse to incur significant out-of-pocket costs in order to receive the same benefits that heterosexual couples are able to receive without incurring those costs—that is, if those LGBTQ individuals can afford the exorbitant out-of-pocket expenses. Aetna's policy also forces LGBTQ individuals to wait longer for treatment, as they must save money in order to afford the required IUIs. Because Aetna has discriminated against me based on my sex and sexual orientation, I am seeking an appeal of the denial of my request for pre-approval.

As a result of Aetna's discriminatory policy, my ability to grow my family is at risk. I do not wish to undergo invasive and time-consuming IUIs simply to meet Aetna's discriminatory definition of infertility, nor can I afford to pay out-of-pocket for the twelve cycles of IUI that Aetna requires before I can access the benefits in my plan. In addition to the exorbitant discriminatory financial burden that Aetna has

placed on my family, this denial of coverage also adds an emotional strain on process that is already emotionally taxing. To be denied coverage because I am gay is a blatant reminder that LGBTQ people are still treated as second class citizens in many ways.

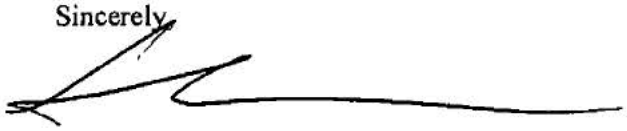
Aetna's policy appears to violate Section 1557 of the federal Patient Protection and Affordable Care Act ("ACA"), which prohibits "any health program or activity, any part of which is receiving Federal financial assistance," including health insurance providers, from discriminating based on sex. *See* 42 U.S.C. § 18116(a). Discrimination based on sexual orientation is sex discrimination. *See Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1741 (2020). As described above, Aetna's application of its definition of infertility is discriminatory because it treats people differently on the basis of their sexual orientation and requires those in same-sex relationships to pay substantial out-of-pocket costs before they can access the benefits in their plans that heterosexual individuals can access without any out-of-pocket expense.

Further, Aetna appears to be aware that this type of policy is discriminatory. In press statements in response to a New York class action lawsuit on behalf of LBGTQ people who have been denied insurance coverage for fertility treatments, Aetna has acknowledged that this type of denial of coverage violates a New York antidiscrimination insurance law. *See* https://www.modernhealthcare.com/insurance/aetna-walks-back-lgbtq-infertility-coverage-policy-after-discrimination-lawsuit. My situation is the same as the one faced by the plaintiffs in that lawsuit, and federal antidiscrimination insurance law is indistinguishable from New York's antidiscrimination insurance law in this respect. Additionally, I know that Aetna must make claim determinations in line with generally accepted medical standards, and the Ethics Committee of the American Society for Reproductive Medicine ("ASRM") recently affirmed that it is unethical to treat requests for assisted reproduction differently with regard to sexual orientation. *See* https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/access_to_fertility_treatment_by_gays_lesbians_and_unmarried_persons-pdfmembers.pdf. Aetna's denial of my claim is directly at odds with that opinion.

Thus, I am requesting an appeal of the denial of my coverage. In making this request, I reserve my "Independent Review Rights" as stated in the overview of the entire appeal process, and all legal protections, whether asserted explicitly in this letter or not, including but not limited to external review and litigation rights. Further, I assert that Aetna's discriminatory policy may violate other state and federal laws, and I do not waive rights to those claims by not asserting them here, but rather reserve those potential protections in case of further review.

Respectfully, I request that Aetna provide me with immediate coverage. If Aetna denies my appeal, I respectfully request that any reply contain a detailed response to my federal discrimination allegation and an explanation of how Aetna's practices and policies are not discriminatory. Additionally, I request that Aetna provide me with copies of all of the documents upon which it relied in denying my appeal.

Sincerely,



Mara Berton

Mara Berton
[redacted]
I ♥ THE EAST BAY SPCA

OAKLAND CA 945
14 JUN 2022 PM 6 L

Aetna
National Accounts CRT
P.O. Box 14001
Lexington, KY 40512

40512-400101

EXHIBIT C

aetna™
Customer Resolution Team
PO Box 14001
Lexington, KY 40512-4001

Category code: CRTM

MARA BERTON
[redacted]

aetna™ Customer Resolution Team
PO Box 14001
Lexington, KY 40512-4001

Category code: CRTM

6-30-2022

DCN# 220630050614

MARA BERTON
[redacted]

Member name: Mara Berton
Member number [redacted]
Case number(s): 2022062104907

Dear Requestor:

We're responding to your request about the case number above.

We have reviewed the file and would like to share our findings with you. The attached letter explains our findings and how we made our decision on this request.

We look forward to serving you in the future. Thank you.

Sincerely,

Namdeo Z

Namdeo Z
Complaint and Appeal Analyst
Customer Resolution Team

DCN# 220630050614
MARA BERTON 6-30-2022 Category code: CRTM

Customer Resolution Team
PO Box 14001
Lexington, KY 40512

June 30, 2022

Mara Berton
[redacted]

Subscriber Name:	June Higginbotham
Member Name:	Mara Berton
Member ID Number:	[redacted]
Provider Name:	
Date(s) of Service:	NA
Patient Account Number:	NA
Payer:	Aetna Life Insurance Company
Case Number(s):	2022062104907

We want to share our decision on your appeal

Dear Appellant:

We reviewed your concerns, which we received on June 19, 2022, about your recent precertification request. Here's our decision.

What we reviewed
We are responding to the appeal of our decision on the following issue:

- The denial of the coverage for listed code(s) 58322 times [redacted]

We reviewed all available information, including:

- The appeal request
- Clinical judgement
- The denial letter
- The previously submitted documentation
- Aetna's Clinical Policy Bulletin (CPB) number 0327, Infertility, review date May 03, 2022
- The Summary Plan Description (SPD) for Encore Group USA LLC.

Our decision on this appeal
After reviewing the information above, we are standing by our earlier decision to uphold denial of the coverage for listed code(s) 58322 times [redacted]

How we made our decision
We understand you are appealing denial of the coverage for listed code(s) 58322 times [redacted]

We consider an individual infertile if the individual is unable to conceive or produce conception after one (1) year of frequent, unprotected heterosexual sexual intercourse, or six (6) months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least twelve (12) cycles of donor insemination (six (6) cycles for women 35 years of age or older). Meeting the definition of infertility is a requirement of the member's insurance plan. Our records don't show the member meet these criteria.

According to the "**Medical necessity and precertification requirements**" section of the SPD for Encore Group USA LLC.,

- [redacted]

Please refer the "**Medically necessary/medical necessity**" definition located in the "**Glossary**" section of the SPD, which states:

[redacted]

You may obtain the Clinical Policy Bulletin pertaining to "Infertility" the Internet at: www.aetna.com.

An Aetna medical director, board certified in obstetrics & gynecology, with a professional designation of MD, an appeals nurse consultant, who is registered nurse (RN) and two data entry operators, all of whom were not involved in any prior decision, participated in the review of the appeal.

Access to relevant information
You can request access to copies of all documents, records and other information about this claim for benefits. There's no charge for this. We will include the specific rule, guideline, protocol or other similar criterion we used in making our decision. It also includes the names of any clinical reviewers if applicable.

The member, doctor or other provider may have sent us diagnosis and treatment codes with your request for authorization of services. To get these codes and their meanings, call us at the number on

the member's ID card. Contact the member's doctor or other provider with any medical questions about the diagnosis or treatments.

You can appeal this decision
If you disagree with this decision, you may request a second level appeal. If you choose to appeal, please forward any additional relevant information that you would like us to consider.

The enclosed document, Aetna Appeal Process and Member Rights, has:

- Instructions on how to appeal
- An overview of the entire appeal process.

We are here to answer your questions
If you have questions about this appeal decision or the appeal process, call us at the number on the member's ID card. Be sure to include the case number when responding or asking about this issue. You can find it at the top of this letter.

Let us know what you think
We have a short survey about our appeal process. Can you help us by answering its questions? Just go to **aetna.com/form_assets/members/survey.html**.

Sincerely,

Namdeo Z

Namdeo Z
Complaint and Appeal Analyst
Customer Resolution Team

Enclosure(s): Aetna Appeal Process and Member Rights
Member Complaint and Appeal Form
Language Enclosure

EXHIBIT D

Aetna Customer Resolution Team
P.O. Box 14001
Lexington, KY 40512

August 7th, 2022

To Whom It May Concern:

My name is Mara Berton, I am 31 years old, and I am enrolled in a health insurance plan administered by Aetna Life Insurance Company. The primary policy holder is my wife, June R. Higginbotham. The member ID Number is [redacted] The plan sponsor is Encore Group USA LLC, and the Plan Sponsor Account Number is 109216-13-002-M. I am writing this second level appeal request regarding Case Number 2022062104907 (Original Case number 8718520210000000).

Beginning in January 2022, I sought infertility treatments from [redacted] an in-network provider. Because I am a woman married to a woman, I need infertility treatments to conceive. My doctor submitted a request to Aetna for pre-approval for [redacted] Soon after, an Aetna representative called me about my request for coverage. The representative did not ask me any questions or gather any information about my situation. I was immediately told that I was denied coverage. Soon after, on February 25th, I received a notice from Aetna officially denying coverage. The notice said that I could not receive coverage because I failed to meet the definition of infertility contained in my plan and in Aetna's national Clinical Policy Bulletin #0327 (CPB), which requires that Aetna plan members who are unable to engage in "1 year of frequent, unprotected heterosexual sexual intercourse" must pay out-of-pocket for 6–12 cycles of donor insemination overseen by a physician *before* Aetna will provide coverage for ART.

I appealed the decision with significant information explaining that the Clinical Policy Bulletin #0327 is discriminatory and requested that Aetna respond to the allegations. In response, Aetna restated their discriminatory definition of infertility from Clinical Policy Bulletin #0327, failed to respond to the federal discrimination allegations, and issued a second denial of coverage. I am submitting a second appeal and again requesting that Aetna respond to the information I have provided claiming federal discrimination. Repeatedly explaining the discriminatory policy to me does not change the fact that it is discriminatory.

Under federal law, it is unlawful for health insurance companies to discriminate based on sex, including sexual orientation, but Aetna treats cisgender heterosexual individuals differently from individuals in same-sex relationships. Aetna forces those unable to engage in heterosexual sexual intercourse to incur significant out-of-pocket costs in order to receive the same benefits that heterosexual couples are able to receive without incurring those costs—that is, if those LGBTQ individuals can afford the exorbitant out-of-pocket expenses. Aetna's policy also forces LGBTQ individuals to wait longer for treatment, as they must save money in order to afford the required IUIs. Because Aetna has discriminated against me based on my sex and sexual orientation, I am seeking an appeal of the denial of my request for pre-approval.

As a result of Aetna's discriminatory policy, my ability to grow my family is at risk. I do not wish to undergo invasive and time-consuming IUIs simply to meet Aetna's discriminatory definition of infertility, nor can I afford to pay out-of-pocket for the twelve cycles of IUI that Aetna requires before I can access the benefits in my

plan. In addition to the exorbitant discriminatory financial burden that Aetna has placed on my family, this denial of coverage also adds an emotional strain on process that is already emotionally taxing. To be denied coverage because I am gay is a blatant reminder that LGBTQ people are still treated as second class citizens in many ways.

Aetna's policy appears to violate Section 1557 of the federal Patient Protection and Affordable Care Act ("ACA"), which prohibits "any health program or activity, any part of which is receiving Federal financial assistance," including health insurance providers, from discriminating based on sex. *See* 42 U.S.C. § 18116(a). Discrimination based on sexual orientation is sex discrimination. *See Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1741 (2020). As described above, Aetna's application of its definition of infertility is discriminatory because it treats people differently on the basis of their sexual orientation and requires those in same-sex relationships to pay substantial out-of-pocket costs before they can access the benefits in their plans that heterosexual individuals can access without any out-of-pocket expense.

Further, Aetna appears to be aware that this type of policy is discriminatory. In press statements in response to a New York class action lawsuit on behalf of LBGTQ people who have been denied insurance coverage for fertility treatments, Aetna has acknowledged that this type of denial of coverage violates a New York antidiscrimination insurance law. *See* https://www.modernhealthcare.com/insurance/aetna-walks-back-lgbtq-infertility-coverage-policy-after-discrimination-lawsuit. My situation is the same as the one faced by the plaintiffs in that lawsuit, and federal antidiscrimination insurance law is indistinguishable from New York's antidiscrimination insurance law in this respect. Additionally, I know that Aetna must make claim determinations in line with generally accepted medical standards, and the Ethics Committee of the American Society for Reproductive Medicine ("ASRM") recently affirmed that it is unethical to treat requests for assisted reproduction differently with regard to sexual orientation. *See* https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/access_to_fertility_treatment_by_gays_lesbians_and_unmarried_persons-pdfmembers.pdf. Aetna's denial of my claim is directly at odds with that opinion.

Thus, I am requesting a second level appeal of the denial of my coverage. In making this request, I reserve my "Independent Review Rights" as stated in the overview of the entire appeal process, and all legal protections, whether asserted explicitly in this letter or not, including but not limited to external review and litigation rights. Further, I assert that Aetna's discriminatory policy may violate other state and federal laws, and I do not waive rights to those claims by not asserting them here, but rather reserve those potential protections in case of further review.

Respectfully, I request that Aetna provide me with immediate coverage. If Aetna denies my second level appeal, I respectfully request that any reply contain a detailed response to my federal discrimination allegation and an explanation of how Aetna's practices and policies are not discriminatory. Additionally, I request that Aetna provide me with copies of all of the documents upon which it relied in denying my appeal.

Sincerely,

Mara Berton

Mara Berton
[redacted]

I ♥ THE EAST BAY SPCA

OAKLAND CA 945
16 AUG 2022 PM 7 L

Aetna Customer Resolution Team
PO BOX 14001
Lexington KY 40512

40512-400101

EXHIBIT E

aetna™
Customer Resolution Team
PO Box 14001
Lexington, KY 40512-4001

Category code: CRTM

[redacted]

aetna™ Customer Resolution Team
PO Box 14001
Lexington, KY 40512-4001

Category code: CRTM

9-5-2022

DCN# 220905053322

MARA BERTON
[redacted]

Member name: Mara Berton
Member number[redacted]
Case number(s): 2022062104907

Dear Requestor:

We're responding to your request about the case number above.

We have reviewed the file and would like to share our findings with you. The attached letter explains our findings and how we made our decision on this request.

We look forward to serving you in the future. Thank you.

Sincerely,

Saeed B

Saeed B
Complaint and Appeals Analyst
Customer Resolution Team

Customer Resolution Team
PO Box 14001
Lexington KY 40512

September 5, 2022

Mara Berton
[redacted]

Subscriber Name:	June Higginbotham
Member Name:	Mara Berton
Member ID Number:	[redacted]
Provider Name:	
Date(s) of Service:	N/A
Patient Account Number:	N/A
Payer:	Aetna Life Insurance Company
Case Number(s):	2022062104907

We want to share our final appeal decision with you

Dear Appellant:

We reviewed your concerns, which we received on August 24, 2022 about your recent precertification request. Here's our decision.

What we reviewed
We are responding to the appeal of our decision about the following issue:
- The denial of the 58322 times [redacted]

We reviewed all available information, including:
- The level two appeal request
- The level one appeal files
- Aetna's Clinical Policy Bulletin (CPB) number 0327, Infertility
- The Summary Plan Description (SPD) for Encore Group USA LLC.

Our decision on this appeal
After reviewing the information above, we are standing by our earlier decision to uphold the denial of the 58322 times [redacted]

How we made our decision
You are appealing for the denial of the 58322 times [redacted]

We consider a member to be infertile if she is unable to conceive or produce conception after one (1) year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce

conception after at least twelve (12) cycles of donor insemination (six (6) cycles for women 35 years of age or older).
Meeting the definition of infertility is a requirement of your insurance plan. Our records don't show you meet these criteria. Therefore, the requested services are not covered.

Please refer to the "**Coverage and exclusions**" section of the SPD, which states:

Please also see the section titled: "**Glossary**" in the SPD, that states:

You may obtain free of charge a copy of the clinical criteria by contacting our Member Services department or you may obtain the Aetna's CPB to Obesity Surgery, number: 0157 through the Internet at: www.aetna.com.

An Aetna medical director, board certified in obstetrics and gynecology, with a professional designation of MD, an appeals nurse consultant with a professional designation of RN and two complaint and appeal analysts, who were not involved in any prior decision, participated in the review of the appeal.

Access to relevant information
You can request access to copies of all documents, records and other information about this claim for benefits. There's no charge for this. We will include the specific rule, guideline, protocol or other similar criterion we used in making our decision. It also includes the names of any clinical reviewers if applicable.

The doctor or other provider may have sent us diagnosis and treatment codes with your request for authorization of services. To obtain these codes and their meanings, call us at the number on the member's ID card. Contact the member's doctor or other provider with any medical questions about the diagnosis or treatments.

You can have an external review of this decision
If you disagree with this decision, **you may request an external review**. The enclosed document, Aetna Appeal Process and Member Rights, has instructions on how to appeal and an overview of the appeal process.

We are here to answer your questions
If you have more questions about this appeal decision or the appeal process, call us at the number on the member's ID card. Be sure to include the case number when responding or asking about this issue. You can find it at the top of this letter.

Let us know what you think
We have a short survey about our appeal process. Can you help us by answering its questions? Just go to **aetna.com/form_assets/members/survey.html**.

Sincerely,

Saeed B

Saeed B
Complaint and Appeal Analyst
Customer Resolution Team

Enclosure(s):
Aetna Appeals Process and Member Rights
Request for External Review Form
Authorization for Release of Protected Health Information (PHI)
Language Enclosure

EXHIBIT F

Case Summary for –2022062104907 as of 04/17/2023 **Printed By:** **A661517 - CSP Inquiry**

Patient/Subscriber Information:

Patient Name	**Mara Berton**	Cumb ID	[redacted]	Patient DOB	[redacted]
Gender	**Female**	PCP/PBG		Jurisdiction State	**California**
Subscriber Name	**June Higginbotham**	Effective Date	**08/26/2021**	Term Date	**12/31/9999**

Complainant:

Contact By:	**Member**	Name:	**Mara Berton**	Contact Telephone No:	[redacted]
Contact Method:	**Letter**	Regulatory Agency:		DOI State:	**N/A**
External Ref No:		DOI Letter Date/Time:	**N/A**	Executive Response:	**No**
On Behalf of:	**Member**	Representation Form:	**Not Required**	Rep Form Returned:	

Provider Information:

Provider Name	[redacted]	Provider PIN	[redacted]	Provider Type	**Physician**
Network Name	**Pos Northern Ca**	Network ID	**00346**	Network Status	**Operational**
Product	**MC**	Effective Date	**02/01/2008**	Termination Date	**12/31/9999**
Telephone Number	[redacted]	POIN		POIN Name	

Plan Sponsor/Product:

Plan Sponsor Name:	**ENCORE GROUP USA LLC.**	Sponsor/Plan Number:	**010921601300002**	Market Sub-Segment:	**Nat Accts Corp**
Product Type:	**AE POS**	Fiduciary:	**Aetna**	Contract State:	**Illinois**
Funding:	**Self-Insured**	Option:	**Process 1**	Levels of Appeal:	**Two Level Process**
Org Name:	**Aetna**	Org Type:	**Carrier**	Org Arrangement Name:	**Default Arrangement**

Case Demographics:

Case ID:	**2022062104907**	Case Owner:	**Medical, Member, Clinical Resolves**		
Case Type:	**Appeal**	Case Level:	**LEVEL2**	Case Status:	**Closed**
LOB Indicator:		Launched By:	**N1CG0001**	Priority:	**Standard**
Expedited:	**No**	Exp Rsn:	**N/A**	Exp Den Rsn:	**N/A**
DOL:	**Yes**	Utilization Review:	**Yes**	ERO Eligible:	**ERO - Federal**
Pre/Post Srvc:	**Pre-Service**	Case Rcvd:	**08/24/2022 09:40 AM**	Case Due:	**09/08/2022 05:00 PM**

Level	Review Type	Case Owner	Rcvd Date	Due Date	Closed Date	Decision Maker	Determination	Case TAT
LEVEL1	Internal Health Plan Review	N371591	06/19/2022	07/04/2022	06/30/2022	A445492	Upheld	11 Days (C)
LEVEL2	Specialist Match	N431904	08/24/2022	09/08/2022	09/05/2022	A617073	Upheld	12 Days (C)

Related Images:

Start Page	DCN	Date Received	Image Type	Description
1	220622057684	06/22/2022	Cover Sheet	Cover Sheet for the images
2	220622057684	06/22/2022	Others	ATV Denial letter
1	220620121199	06/22/2022	Front End Imaging	Appeal Request
1	220630050614	06/30/2022	Front End Imaging	Resolution Letter
1	220824082909	08/26/2022	Front End Imaging	Appeal request
1	220905053322	09/05/2022	Front End Imaging	Resolution Letter

Initial Determination By:

Category:	**Aetna Patient Management (PM)**	Reference No:	**8718520210000000**	Original Denial Date	**02/21/2022**

Services being appealed:

Item Determination:	**Upheld**	Resolution Short Description:	**Clinical Interpretation**		
Segment:	**Shared Services**	Business Unit:	**MPO-NCAU**	Site:	**MPO Letter Return**
Reviewer:	**Kristen Egidi**	Status:	**Closed**		

No	DOS	Category	Description	Detail	State	Claim No	Cost	DX	PX

001		Appeal	Outpatient Denial	Infertility	California				

Case Comments:

Level	Comment Date	Comment Entered By	Comment Type	Comment
LEVEL1	06/21/2022	N1CG0001	CSP Comments	Member s consent to use name in the investigation No DCN 220620121199 RECEIVED DATE: 06/20/2022 SUBSCRIBER ID: [redacted] SUBSCRIBER GROUP: 0109216 FIRST NAME: MARA LAST NAME: BERTON REFERENCE ID: NA FORM TYPE: PRE/POST SERVICE IND: 1 ETUMS/ATV ID: 8718-5202-1000-0000 SERVICE DATE: NA DENIAL DATE NA PROVIDERAPPEALCLINICALIND Y CLAIMRECONSIDERATIONIND: N DENIAL CODES: NA HMO CLAIM ID: NA ACKNOWLEDGMENT LETTER REQUIRED: NO ACKNOWLEDGMENT LETTER DCN: NA RELATED CASE ID: NA COMMENTS: ATV DENIED DATE 02/21/2022, LEVEL 1
LEVEL1	06/21/2022	N1CG0001	CSP Comments	ASD Interface Case Details ASD Funding Arrangement SI ASD Contract State: IL ASD Claim #: ASD Claim Provider Name: ASD Claim Provider TIN ASD Claim Provider ID: ASD Claim Diagnosis Code: ASD Claim Procedure Code: ASD Claim From DOS ASD Claim to DOS: ASD Claim Submitted Amt: ASD Claim DCN:
LEVEL1	06/21/2022	N1CG0001	Case Comments	Warning, This case is a potential Duplicate Case
LEVEL1	06/22/2022	N901051 - Sanket Kamble	Item Comments	UM Prep Reference No: 8718-5202-1000-0000 SOE Type Utilization Management All Other Medical Benefit Exclusion: No SIU Related: No Initial Denial Reason: Medical Necessity Pre Service SERVICE CODE 58322 x 6 DX: Z31.9- [redacted] Claim Subject to High Dollar Claim Policy: No Previous Decision Maker: Yambao, Maria C Additional Comments:. ATV #8718-5202-1000 Denied Non-Participating Provider: False
LEVEL1	06/22/2022	N901051 - Sanket Kamble	Case Comments	CLAIM FIDUCIARY RESPONSIBILITY AETNA PERFORMS FULL CLAIM FIDUCIARY ERISA - INCLUDES FEDERAL EXTERNAL REVIEW PROGRAM HEALTH CARE REFORM PLAN STATUS FULLY COMPLIANT Grandfathering NON-GRANDFATHERED Appeals • Aetna Standard
LEVEL1	06/22/2022	N901051 Sanket Kamble	Plan Documents	https //www aetna com/epublishing/getPlanDocument? serviceName=fetchDocument&nodeId=344297041&type=PDF&name=MDRXBK20SF-04.PDF&dms=P
LEVEL1	06/22/2022	N901051 Sanket Kamble	Case Comments	Upload Successful! Tracking Number: 025ba4fe 588c 40f1 a31f a7294a54b400
LEVEL1	06/24/2022	A304656 - Rena Floyd	Nurse Prep	NCAU-UM Appeal Issue: Member 1st level appeal regarding the denial of the listed code(s) 58322 x [redacted] Date of Service: Pre-service

				State Licensure Required? No Specialty Matched Review Required? No Date of previous discharge (DRG readmission): N/A Hospital LOC Contracted Rates: N/A Clinical Summary: 30 y/o Mbr w/ dx reported as Z31.9- [redacted] Summary of New Information Received: Beginning in January 2022, I sought infertility treatments from [redacted] an in-network provider. Because I am a woman married to a woman, I need infertility treatments to conceive. My doctor submitted a request to Aetna for pre-approval fo [redacted] Images Index: Original denial letter DCN 7684 3 Appeal letter DCN 1199 p1 Original Denial Rationale: medical necessity ATV SOE: 8718-5202-1000-0000 MD Name: Yambao, Maria, C, . admin deny [redacted] per plan benefit SPD Unique ID#341562752 (01/01/2021)- did not meet the definition of infertility [redacted] Criteria used for initial determination: CPB 327 P2P done: N/A NCAU Recommendation: Consider uphold of the following Per criteria, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older). Documentation submitted does not meet criteria. SPD/ COC Language: Med Nec Sources: the appeal request, original denial letter, previously submitted documentation Resources: The plan documents for ENCORE GROUP USA LLC. Clinical Policy Bulletin (CPB) # 0327, Infertility review date 05/03/2022 Nurse Name/ Site: Rena Floyd, RN, MHA - Appeals Nurse Consultant, WAH/MPO-2
LEVEL1	06/24/2022	A304656 - Rena Floyd	Item Comments	Initial denial by: Yambao, Maria, C, . Licensure Need: No Specialty Need: No Lvl 1 Panel: N/A Comment: Please return to Shared Services, UM-NCAU, Member, Rena Floyd, RN, MHA
LEVEL1	06/27/2022	A445492 - Andrea Jones	Health Plan Determination	Member Letter: Resolution: Denial Clinical Denial: clinical: Med Nec Denial Letter ready explanation:

				We consider an individual infertile if the individual is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older). Meeting the definition of infertility is a requirement of your insurance plan. Our records don't show you meet these criteria. SPD/COC reference: medical necessary Comment: deny all codes Per the submitted clinical records, the member has never attempted to conceive. Reference: CPB# 327 in effect for date of service, SPD, clinical judgment
LEVEL1	06/28/2022	A737847 - Gailmarie Kaufmann	Health Plan Determination	NCAU Letter Language for CRT – Uphold or Partial Uphold § Information Reviewed: the appeal request, original denial letter, previously submitted documentation, The plan documents for ENCORE GROUP USA LLC. And Clinical Policy Bulletin (CPB) # 0327, Infertility review date 05/03/2022 § Our Decision: Uphold or Partial Uphold: Precert § Uphold (Deny): listed code(s) 58322 times [redacted] § Clinical explanation: We consider an individual infertile if the individual is unable to conceive or produce conception after one (1) year of frequent, unprotected heterosexual sexual intercourse, or six (6) months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older). Meeting the definition of infertility is a requirement of the member's insurance plan. Our records don't show the member meet these criteria. § CRT to include Plan Language relating to: medically necessary § CRT to include Clinical Criteria web statement: include reference to Infertility § REVIEWERS or PANEL REVIEWERS: • Medical Director: Andrea Jones, MD, Obstetrics & Gynecology • Nurses: Appeals Nurse Consultant, RN • Analyst: Senior Coordinator Appeals and Complaints Next Steps (for Level 1 when plan has 2 levels): None – NOTE TO CRT: delete hidden text
LEVEL1	06/30/2022	N371591 - Namdeo Zodape	Resolution Comments	Upheld
LEVEL2	08/26/2022	N910343 - Veenashri Puthane	Item Comments	Second level case received under Case ID #2022082601559 Member's consent to use name in the investigation:Yes:DCN: 220824082909 RECEIVED DATE: 08/24/2022 SUBSCRIBER ID: [redacted] SUBSCRIBER GROUP: 0109216 FIRST NAME: MARA LAST NAME: BERTON REFERENCE ID: NA FORM TYPE: PRE/POST SERVICE IND: 1 ETUMS/ATV ID: 8718-5202-1000 SERVICE DATE: NA DENIAL DATE: NA PROVIDERAPPEALCLINICALIND: CLAIMRECONSIDERATIONIND: N DENIAL CODES: NA HMO CLAIM ID: NA ACKNOWLEDGMENT LETTER REQUIRED: NO ACKNOWLEDGMENT LETTER DCN: NA RELATED CASE ID: 2022062104907 COMMENTS: ATV DENIED ON 02/21/2022, LEVEL 2 APPEAL
LEVEL2	08/26/2022	N910343 - Veenashri Puthane	Item Comments	CLAIM FIDUCIARY RESPONSIBILITY AETNA PERFORMS FULL CLAIM FIDUCIARY - ERISA - INCLUDES FEDERAL EXTERNAL REVIEW PROGRAM HEALTH CARE REFORM PLAN STATUS FULLY COMPLIANT Grandfathering NON-GRANDFATHERED Appeals • Aetna Standard
LEVEL2	08/26/2022	N910343 - Veenashri Puthane	Item Comments	UM Prep Reference No: 8718-5202-1000-0000 SOE Type: Utilization Management - All Other Medical Benefit Exclusion: No SIU Related: No

				Initial Denial Reason: Medical Necessity Pre-Service: SERVICE CODE 58322 x 6 DX: Z31.9-[redacted] Claim Subject to High Dollar Claim Policy: No Previous Decision Maker: A445492 - Andrea Jones, MD Additional Comments:. ATV #8718-5202-1000 Denied Non-Participating Provider: False
LEVEL2	08/26/2022	N910343 - Veenashri Puthane	Plan Documents	SPD link: https://www.aetna.com/epublishing/getPlanDocument?serviceName=fetchDocument&nodeId=344297041&type=PDF&name=MDRXBK20SF-04.PDF&dms=P
LEVEL2	09/01/2022	A159647 - Kristen Egidi	Nurse Prep	NCAU Case Review Template Appeal Issue: LVL 2: MOBM is requesting reconsideration for the denial of 58322 [redacted] Specialty Matched Review Required? yes: infertility State Licensure Required? n/a Date of Service: preservice Clinical Summary: Member is a 31 year old female, requesting infertility treatments. She is a woman married to a woman. No infertility treatment noted to date. Summary of New Information Received: per the appeal letter: "As a result of Aetna's discriminatory policy, my ability to grow my family is at risk. I do not wish to undergo invasive and time-consuming IUIs simply to meet Aetna's discriminatory definition of infertility, nor can I afford to pay out-of-pocket for the twelve cycles of IUI that Aetna requires before I can access the benefits in my plan. In addition to the exorbitant discriminatory financial burden that Aetna has placed on my family, this denial of coverage also adds an emotional strain on process that is already emotionally taxing. To be denied coverage because I am gay is a blatant reminder that LGBTQ people are still treated as second class citizens in many ways." Images Index: 220824082909 Pg. 1: appeal letter Original Denial Rationale: ATV SOE: 8718-5202-1000-0000 MD Name: Yambao, Maria, C, . admin deny IUI per plan benefit SPD Unique ID#341562752 (01/01/2021)- did not meet the definition of infertility [redacted] LVL 1 member appeal: Andrea Jones: We consider an individual infertile if the individual is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older). Meeting the definition of infertility is a requirement of your insurance plan. Our records don't show you meet these criteria. Criteria used for initial determination: CPB 327 NCAU Recommendation: Consider uphold. Per the members medical plan documents: for a female without a male partner, she will be diagnosed [redacted] SPD/COC Language (specify which): Pg. 58: Infertility Infertility: A disease defined by the failure to become pregnant: • For a female with a male partner, after: - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35 - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older • For a female without a male partner, after: - At least 12 cycles of donor insemination if under the age of 35 - 6 cycles of donor insemination if age 35 or older • For a male without a female partner, after: - At least 2 abnormal semen analyses

				obtained at least 2 weeks apart • For an individual or their partner who has been clinically diagnosed with gender identity disorder. Sources: appeal letter, Resources: Clinical Policy Bulletin (CPB) # 0327, Infertility review date 08/01/2022 and Choice POS II medical plan – (Traditional PPO Plan) Booklet Prepared for Encore Group USA LLC. Nurse Name/Title: Kristen Egidi, RN, BSN, Appeals Nurse Consultant
LEVEL2	09/01/2022	A159647 - Kristen Egidi	Item Comments	Initial reviewer/s: Maria Yambao and Andrea Jones Licensure: n/a Specialty: yes: infertility L1 Panel Case (member only): n/a Comment: return to Shared Services, UM-NCAU, UM Letter Return
LEVEL2	09/02/2022	A617073 - Lara Fisher	Specialist Determination	Member Letter: Resolution: Denial Clinical Denial: clinical: Exp/ Inv denial Letter ready explanation: We consider a member to be infertile if she is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older). Meeting the definition of infertility is a requirement of your insurance plan. Our records don't show you meet these criteria. Therefore, the requested services are not covered. SPD/COC reference: exp/inv Comment: deny all codes Reference: CPB# 327 in effect for date of service
LEVEL2	09/02/2022	A159647 - Kristen Egidi	Health Plan Determination	NCAU Letter Language for CRT – Uphold or Partial Uphold § Information Reviewed: appeal letter, Clinical Policy Bulletin (CPB) # 0327, Infertility and Choice POS II medical plan – (Traditional PPO Plan) Booklet Prepared for Encore Group USA LLC. § Our Decision: Uphold or Partial Uphold: precert § Uphold (Deny): 58322 x [redacted] § Clinical explanation: We consider a member to be infertile if she is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is 35 years of age or older. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women 35 years of age or older). Meeting the definition of infertility is a requirement of your insurance plan. Our records don't show you meet these criteria. Therefore, the requested services are not covered. § CRT to include Plan Language relating to: infertility § CRT to include Clinical Criteria web statement: include reference to Infertility § REVIEWERS or PANEL REVIEWERS: • Medical Director: Lara Fisher MD, board certified in Obstetrics and Gynecology • Nurses: Appeals Nurse Consultant RN • Analyst: Include titles of any and all analysts involved with case

				Next Steps (for Level 1 when plan has 2 levels): None – NOTE TO CRT: delete hidden text
LEVEL2	09/02/2022	A159647 - Kristen Egidi	Specialist Determination	uphold
LEVEL2	09/05/2022	N431904 - Saeed Bagwan	Resolution Comments	Upheld

Letter History:

Number	Date	Due Date	Type	Level	Method	Sender	To	CC	Address
1	06/22/2022 11:01 PM		Acknowledgement Letter	1	Automated	U1CG0992			
2	06/30/2022 01:40 AM		Resolution Letter	1	Manual Letter	N371591			
3	09/05/2022 06:28 AM		Resolution Letter	2	Manual Letter	N431904			

Case Resolution Information:

Level	Decision Maker Title	User ID	Name	Verbal Notification	Case Closed Date/Time	Case TAT	Determination	Resolution Short Description
LEVEL1	Medical Director	A445492	Jones		06/30/2022 01:40 AM	11 Days (C)	Upheld	Clinical Interpretation
LEVEL2	Medical Director	A617073	Fisher		09/05/2022 06:27 AM	12 Days (C)	Upheld	Clinical Interpretation

MEAGHAN VERGOW (*admitted pro hac vice*)
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O'MELVENY & MYERS LLP
1625 Eye Street, NW
Washington, DC 20006
Telephone: (202) 383-5300
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Los Angeles, California 90067-6035
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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARA BERTON, on behalf of herself and all others similarly situated,

Plaintiff,

v.

AETNA INC. and AETNA LIFE INSURANCE COMPANY,

Defendants.

Case No. 4:23-cv-01849-HSG

[PROPOSED] ORDER GRANTING DEFENDANTS' MOTION TO DISMISS COMPLAINT

Hearing Date: October 12, 2023
Time: 2:00 p.m.
Location: Ronald V. Dellums Federal Building, 1301 Clay Street, Oakland, CA 94612 Courtroom 2, 4th Floor

[PROPOSED] ORDER

Defendants Aetna Inc. and Aetna Life Insurance Company's (collectively "Defendants") Motion to Dismiss the Complaint ("Motion to Dismiss") came on for hearing before this Court on October 12, 2023 at 2:00 p.m. After considering the briefs submitted in support of and in opposition to the Motion to Dismiss and hearing argument from counsel, the Court hereby GRANTS Defendants' Motion to Dismiss.

First, the Complaint is dismissed pursuant to Federal Rules of Civil Procedure 12(b)(6). The Complaint fails to state a claim under Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116(a) ("Section 1557"), because Plaintiff does not plausibly allege intentional discrimination on the basis of sex or sexual orientation. As an initial matter, Plaintiff fails to plausibly allege that the denial of her requested treatment was discriminatory at all because the coverage terms Plaintiff challenges apply in equal fashion to individuals outside the claimed protected class. Additionally, Plaintiff's allegations at most give rise to a disparate impact claim of discrimination, which is insufficient to state a claim under Section 1557 or under Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 *et seq.*, on which Section 1557 is based. Dismissal pursuant to Rule 12(b)(6) is also appropriate because the Employee Retirement Income Security Act of 1974 ("ERISA") provides the exclusive remedy for individuals who, as here, assert a claim for improper denial of benefits under an ERISA-governed health plan.

Second, Plaintiff has failed to join a necessary party to this action—the health plan's sponsor and plan administrator—and the Complaint is therefore dismissed pursuant to Rule 12(b)(7) as well.

While the Court agrees with Defendants that the Complaint should be dismissed in its entirety pursuant to Rules 12(b)(6) and 12(b)(7) for the reasons stated herein, the Court also notes that Aetna Inc. is not a proper party to this lawsuit because it does not provide health insurance and had no involvement with administering the benefit plan at issue in this litigation.

For all these reasons, Defendants' Motion to Dismiss is hereby GRANTED. The Court orders dismissal of the Complaint with prejudice because an amendment would be futile.

IT IS SO ORDERED.

Dated:_____

_____
Honorable Haywood S. Gilliam, Jr.
U.S. District Judge