BENEFIT PLAN

Prepared Exclusively For
Terrakotta, Inc. dba Laguna Clay Company

OA Managed Choice POS

Extraterritorial Riders

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna™

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Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Terrakotta, Inc. dba Laguna Clay Company

Group policy number: GP-0269319

Amendment effective date: June 1, 2026

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

Important note: The following apply only if you live in Florida. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

In no event will the covered amount for any covered service or treatment that is not available from an In-Network provider be less than 10% of the covered amount for In-Network charges.

In no event will any Out-Of-Network Deductible be more than four times any In-Network Deductible. If there is no Individual In-Network Deductible, any Out-Of-Network Individual Deductible cannot exceed $500 per individual.

Cleft lip and palate

Covered services include treatment for a congenital cleft lip or cleft palate. This includes:

- Orthodontics
- Oral **surgery**
- Otologic services
- Nutrition services
- Audiological and speech/language treatment involved in the management of birth defects known as cleft lip, cleft palate or both

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due either to age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

Jaw joint disorder treatment

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

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- 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 dental services, and therapeutic services related to **jaw joint disorder**

The following has been added to or replaced in the *Eligibility, starting and stopping coverage, Who can be a dependent on this plan* section of your booklet-certificate.

Who can be a dependent on this plan

- Dependent children – yours or your spouse's or partner's
    - A dependent child who is under 26 years of age will be covered until the end of the calendar year after they have reached age 26 provided they meet all of the following:
        - Attending school regularly (full-time or part-time) or living in your household
        - Solely dependent upon you for support
    - A dependent child from the end of the calendar year in which the child turns age 26 until the end of the calendar year in which the child turns age 30, provided the child is:
        - Unmarried and does not have a dependent of their own
        - A resident of Florida or a full-time or part-time student
        - Not eligible for Medicare and not covered under another group, blanket, franchise or individual health benefit plan

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

A newborn child of a covered dependent other than your spouse, domestic partner, civil union partner is covered for 18 months. At the end of 18 months, coverage for the newborn will be terminated

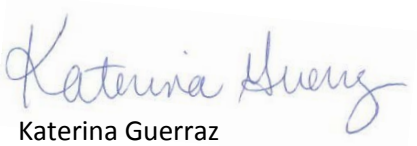
We must receive a completed enrollment form not more than 31 days after the event date.

Why would we end your coverage?
Your coverage may end if you act in a way that prevents you from having a good relationship with a **network provider**. We may also end your coverage if you act in a way that affects our business operations. We will give you 45 days notice in writing if we end your coverage for any of these reasons.

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.

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



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

Amendment: Florida Medical ET
Issue Date: April 24, 2026

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Terrakotta, Inc. dba Laguna Clay Company

Group policy number: GP-0269319

Amendment effective date: June 1, 2026

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Important note: The following apply only if you live in Illinois. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Entire Contract
This policy, including the application and any amendments or inserts, constitute your entire policy. A change to the policy is not valid unless approved by an executive officer of Aetna Life Insurance Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN **OUT-OF-NETWORK PROVIDERS** ARE USED.

YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), non-participating providers furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating provider, plan benefit payments will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. Participating providers have agreed to ONLY bill members the cost-sharing amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Low dose mammography screening, for women age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
  - For women 35-39, a baseline mammogram
  - For women 40 **years** of age and older, annually
  - For women under 40, with a family or prior personal history of breast cancer, positive genetic testing, or other risk factors, at necessary age and intervals
  - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogenous or dense breast tissue, as determined by your **physician**
  - Screening MRI, as determined by your **physician**
- Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your Physician**, PCP**. This includes individuals who are:
  - Asymptomatic individual age 50 and older
  - Individual men age 40 and over
  - Individual age 40 and over with family history of prostate cancer
  - Colorectal cancer screening
- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, and a follow-up exam based on an initial screening.
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 **years**
- Sigmoidoscopies
- Pancreatic cancer screening when medically necessary
- Home saliva cancer screening if they:
  - Are asymptomatic and at high risk for the disease being tested for; or
  - Demonstrate symptoms of the disease being tested for at a physical exam

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 or implant removal
  - Prostheses
  - A physician office visit or in-home nurse visit within 48 hours after discharge

Covered services also include breast reduction **surgery**.

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 as soon as possible with a claim form that you can either get online or contact us to provide You should always keep your own record of the date, **providers** and cost of your services.

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

We will pay the claim immediately 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.

If benefits are not paid within 30 days after proof of loss is received, you are entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.

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.

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

But, 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 you are undergoing treatment for an acute or chronic condition and the **provider** didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

Important note:
If you are pregnant and have entered your second trimester, transitional care will be through the time required for postpartum care directly related to the delivery.

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

Coordination of benefits

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

Key Terms

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

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

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

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

How COB works

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

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information. A plan that does not contain a COB provision is always the primary plan.

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. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

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

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. 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.

Other Insurance in this Company

Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies.

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

Complaints, claim decisions and, appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision. When a complaint is received from the Illinois Department of Insurance, we will respond within 21 days of receiving the complaint.

You may contact the Illinois Department of Insurance at any time. However, you are encouraged to contact us before filing a complaint with the Illinois Office of Consumer Health Insurance. Complaints to the Office of Consumer Health Insurance may be submitted in the following ways:

- Online at https://mc.insurance.illinois.gov/messagecenter.nsf
- By email at consumer_complaints@ins.state.il.us
- By fax to (217) 558-2083
- Office of Consumer Health Insurance hotline telephone number: (866) 445-5364
- By mail to:
  Office of Consumer Health Insurance
  320 W. Washington Street
  Springfield, IL 62767

Appeal

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

Claim decisions and appeal procedures

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

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

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

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

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

The deadline for filing an appeal will not be postponed or delayed by a **provider** appeal unless the **provider** is acting as your authorized representative.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

You may also contact Aetna at the following address and telephone numbers:
Aetna
(ISM) CRT
P.O. Box 14002
Lexington, KY 40512
Toll-free telephone number: (877) 204-9186
Fax: (859) 425-3379

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

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on your member website or by contacting us. The form will tell you where to send it to us.

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

Exhaustion of appeal process

You are encouraged to complete the appeal process with us before you can take these other actions:

- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal
- File a complaint or appeal with the Illinois Department of Insurance
- Appeal through an external review process
- Pursue non-binding arbitration, litigation or other type of administrative proceeding
- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- You filed an appeal under the internal appeal process and we did not provide a written decision within:
    - 30 days from the date you filed an appeal of a concurrent or pre-service claim
    - 60 days from the date you filed an appeal of a post-service claim except to the extent you agreed to a delay
- You filed a request for an expedited internal review and we did not provide a decision within 48 hours, except to the extent you requested or agreed to a delay
- Your **provider** certifies in writing that the recommended health care service or treatment is **experimental or investigational** and would be significantly less effective if delayed
- We did not follow all of the claim determination and appeal requirements of Illinois 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

How your dependent can extend coverage after you die

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 31 days after your death, and
- Payment is made for coverage

Your dependent's coverage will end on the earliest date:

- The expiration of 2 years from the date continuation coverage began
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

To request extension of coverage, the dependent, or their representative, can contact us.

How you can extend coverage for your former spouse if you die or retire (spousal continuation privilege)
You have the right to extend coverage for your spouse if coverage would end because:

- Your marriage ends
- You retired or died

To extend coverage, your former spouse must:

- Apply for continuation of coverage
- Pay the required **premium** within 30 days of the date they receive notice of the right to continue

If your former spouse is under age 55, the right to continue coverage will be extended until the earliest to happen:

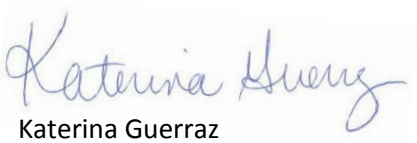
- 2 **years** from the date continuation started
- The date coverage starts under another plan
- The date coverage would otherwise end if the marriage had not ended. This will not apply for the first 120 days following the end of the marriage or your death unless the plan ends due to a change in the plan
- The date the spouse remarries
- The date premiums are not paid

If your former spouse is age 55 or older, the right to coverage will be extended until the earlier to happen:

- The date coverage starts under another plan
- The date coverage would otherwise end if your marriage didn't end, you didn't retire or die. This will not apply for the first 120 days following the end of the marriage, your retirement or your death unless the plan ends due to a change in the plan
- The date the spouse remarries
- The date **premiums** are not paid
- The date they reach the qualifying Medicare age or establish Medicare eligibility

The right to continue coverage also includes dependent children whose coverage began prior to the end of the marriage or death.

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



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

Amendment: Illinois Medical ET
Issue Date: April 24, 2026

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

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Group policy number: GP-0269319

Amendment effective date: June 1, 2026

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Important note: The following apply only if you live in Ohio. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

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 pediatrician, **physician** or **behavioral health provider**, including a psychologist trained in Autism spectrum disorder for:

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

Covered services also include outpatient rehabilitation services, including physical, speech and occupational therapies, and clinical therapeutic interventions. Clinical therapeutic interventions are defined as therapies supported by empirical evidence that include, but are not limited to, applied behavioral analysis, provided by or under the supervision of a professional that is licensed, certified, or registered by an appropriate agency if Ohio to perform the services in accordance with a treatment plan. Please see your schedule of benefits for any benefit limitations.

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.

Covered services also include routine patient care costs, including clinical trial therapies, if you are participating in any stage of an eligible cancer clinical trial as defined by state law and all of the following is met:

- The purpose of the trial is to test whether the intervention may improve the participant's health or the treatment is given with the intention of improving the participant's health, and is not designed to test toxicity or disease pathophysiology
- The trial does one of the following:
  - Tests how to administer and the responses to health care services, items, or drugs for cancer treatment
  - Compares the effectiveness of a health care service, item, or drug for cancer treatment
  - Studies new uses of health care services, items, or drugs for cancer treatment
- The trial is approved by one of the following:
  - The National Institutes of Health
  - The Food and Drug Administration
  - The Department of Defense
  - The Department of Veterans Affairs
  - The Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The Centers for Medicare & Medicaid Services
  - Cooperative group or center of any of the entities described above
  - The Department of Energy

The following are not **covered services** under this section:

- 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)
- A health care service, item, or drug that is subject to the cancer clinical trial or is provided solely to satisfy data collection and analysis and not used in direct clinical management of the patient
- An investigational or experimental drug or device not approved for market by the FDA
- Transportation, lodging, food, or other expenses for the patient, family member, or companion that are associated with travel to or from a facility providing the cancer clinical trial
- An item or drug provided by the cancer clinical trial sponsors free of charge
- A service, item, or drug eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial
- Experimental or investigational treatment

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. This would include coverage of **injury** or sickness and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. 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. The decision can be made by a certified nurse-midwife in collaboration with the attending **physician**.

Precertification is only required for maternity and newborn **stays** that exceed the standard length of **stay**.

If the mother is discharged earlier, **covered services** include post- delivery home visits for follow-up care for the mother and newborn when recommended, ordered and supervised by a health care **provider,** which includes a **physician** or advanced practice registered nurse. If the mother is discharged earlier than the minimum lengths of **stay**, **covered services** include all follow-up care received within 72 hours after discharge. If the mother receives at least the minimum number of hours of inpatient care, we will pay for **covered services** as recommended by the attending **physician**. The home visits include:

- Parent education
- Assistance training in breast or bottle feeding
- Physical assessment of the newborn and mother
- The collection of an adequate sample for the hereditary and metabolic newborn screening
- Clinical tests and other services that are in line with follow-up care recommended in the protocols and guidelines developed by national organizations representing the **providers**

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
- Surrogacy when the surrogate is not a covered person

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment. Coverage will not be less favorable than for intravenously or injected anti-cancer prescription drugs.

Child Health Supervision Services

Child Health Supervision Services include **covered services** for the periodic review of a child's physical and emotional status performed by a **physician, PCP** or other **health professional** from birth to age 9. A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics.

Mammography screening

Covered services include the following routine cancer screening:

- Mammograms, including screening for women:
- Age 35-39, annually
- Age 40-49, every 2 years; or annually for women at increased risk for breast cancer as determined by your provider or health professional
- Age 50-64, every 2 years

Mammograms received out-of-network important note:
The total amount payable by Aetna and you may not exceed 130% of the Medicare reimbursement amount. We will make the payment to your provider or facility in accordance to the plan. No provider shall seek or receive payment in excess of 130% of the Medicare reimbursement amount. Members can only be billed for deductibles, copayments and coinsurances.

Precertification

Precertification must be obtained for opioid analgesics for the treatment of chronic pain except when a drug is prescribed for an individual who is

- a hospice patient
- diagnosed with a terminal condition
- a cancer patient

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). This can be conducted by an ERO or by the Ohio Department of Insurance.

You have a right to external review when you have received an **adverse benefit determination.**

You also have a right to external review only if all the following conditions are met:

- You have received an **adverse benefit determination**
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

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:

- Within 180 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any 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.

There are two types of ERO review, standard and expedited. A standard review is completed within 30 days. An expedited review for urgent medical situations is completed within 72 hours and can be requested of any of the following applies:

- The **provider** treating you can certify that the **adverse benefit determination** involves a medical condition and that it would do any of the following:
  - Seriously jeopardize your life or health
  - Jeopardize your ability to regain maximum function if treatment is delayed until the timeframe of an expedited appeal
  - Jeopardize your ability to regain maximum function if treatment is delayed until the timeframe of a standard external review
- The final adverse determination is for **emergency services** for an admission, availability of care, continued **stay**, or health care services and you have not been discharged from the facility
- The final adverse determination is for an experimental or investigational treatment and the **provider** treating you certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated

Important note:
An expedited external review is not available for health care services that you have already received. Requests for external reviews can be requested in writing, orally, or electronically.

External review with the Ohio Department of Insurance

You have a right to a review from the Ohio Department of Insurance, only if:

- The claim decision did not involve a medical judgment or medical information
- The claim decision was already reviewed by an ERO and the ERO decided that your claim should not be paid
- Your claim was for an **emergency medical condition** determined not to meet the definition of **emergency services**
- And you have completed our internal appeal process

What happens when we receive a request for external review?

When we receive the request for external review, we will:

- Verify the request is complete
- Notify you in writing of the following:
  - The name and contact information for the ERO or the Ohio Department of Insurance in case you want to submit additional information
  - The 10 day timeframe you have to submit additional information to the ERO or Ohio Department of Insurance

If after our review we conclude that we are missing information we will notify you in writing. This notice will indicate what specific information is needed to complete the request. If we determine that the **adverse benefit determination** is not eligible for an external review, we will notify you in writing, and:

- Provide you with the reason for the denial
- Inform you of your right to submit an appeal to the Ohio Department of Insurance

The Ohio Department of Insurance may determine that your request is eligible for an external review even if we did not. In that case, we will initiate the external review with the ERO.

ERO review and decision
The ERO is not obligated to agree with any decisions or conclusions we made during our review or appeal process.

In order for the ERO to be able to make a decision, the ERO must consider:

- All the documents and information we submitted to them that were considered in making the adverse benefit decision
- Any information you submitted
- Other information, such as:
  - Your medical records
  - Your **provider's** recommendations
  - Any consulting reports from appropriate health care professionals
  - The term of coverage under this contract
  - The most appropriate practice guidelines
  - Clinical review criteria we might have used
  - The opinions of the ERO's clinical reviewers

How long will it take to get an ERO decision?
The ERO will tell you of its decision within 30 days once we receive your request for a standard review or no later than 72 hours after the receipt of the request for an expedited review.

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

Important note:
Once you file a request for an external review you cannot request another external review if it involves the same **adverse benefit determination** unless you submit new medical or scientific evidence to us.

If you have questions about your rights or need assistance
You can contact us

You can also contact the Ohio Department of Insurance:
Ohio Department of Insurance
Attn: Consumer Affairs
50 W. Town Street, Third Floor - Suite 300
Columbus, OH 43215
(614) 644-2658
TDD: 614-644-3745
614-644-3745 (TDD)
(800) 686-1526
life.health.mcd@insurance.ohio.gov

Contact ODI Consumer Affairs:
https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Comment.mvc/DisplayCommentSubmission

File a Consumer Complaint:
http://www.insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Adding new dependents

Your newborn child is covered on your health plan for the first 31 days from the moment of birth at no cost.

- Please notify us of the birth within 31 days.
- If your plan requires additional premium, we must receive notification within 31 days of your newborn's birth to continue coverage
- If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

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

Continuation of coverage - State of Ohio

What are your rights?

Ohio law gives some people the right to keep their health coverage for 12 months after active employment ends. To be eligible for this continuation of coverage:

- You must have been employed for three consecutive months immediately before coverage ended
- You could not have voluntarily ended your employment
- Your employment could not have ended for gross misconduct
- You cannot be covered or eligible for any other group plan, Medicare, or COBRA

When do I receive continuation information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/Group health plan notification requirements

Notice	Requirement	Deadline/Method
General notice - Aetna	Notify you and your dependents of continuation rights	Through this certificate
Notice of qualifying event – employer or Aetna	Your active employment ends for reasons other than gross misconduct	At the time the employer notifies you of your loss of employment

How do you enroll?

You enroll by sending in an application and paying the **premium**. The application will tell you how to enroll and how much it will cost.

When is your first premium payment due?

Your first **premium** payment must be made:

- Within 31 days from your employment termination date
- Within 10 days if your employer notified you of your loss of employment before your employment termination date
- Within 10 days if your employer notified you of your right to continue coverage after your employment termination date

How much will this coverage cost?

You and your dependents will pay a monthly premium of 100% of the total plan costs

When does coverage end?
Coverage ends if:

- Coverage has continued for the maximum period
- The plan ends. If the plan is replaced, you may be continued under the new plan
- You and your dependents fail to make the necessary payments on time
- You or a covered dependent become entitled to benefits under Medicare
- You or a covered dependent becomes covered under another plan

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

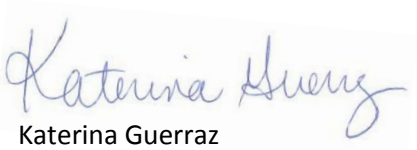
You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

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.

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



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

Amendment: Ohio Medical ET
Issue Date: April 24, 2026

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Terrakotta, Inc. dba Laguna Clay Company

Group policy number: GP-0269319

Amendment effective date: June 1, 2026

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

Important note: The following apply only if you live in Washington. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Abortion

Covered services include services provided and supplies used in connection with an abortion.

Applied behavior analysis

Covered services include applied behavior analysis.
Applied behavior analysis is a process of applying interventions that:

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

Autism spectrum disorder

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

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

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

Clinical trials

Routine patient costs

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

- Phase I
- Phase II
- Phase III, or
- Phase IV

clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Life-threatening disease or condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

A clinical trial must be approved or funded by one or more of the following:

- The National Institutes of Health (NIH)
- An NIH cooperative group or center (a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program)
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- The Department of Veterans Affairs
- The Department of Defense
- An Institutional review board of a Washington institution that has a multiple project contract approval by the Office of Protection for the Research Risks of the NIH

The following are not **covered services**:

- Services and supplies related to data collection and analysis needs not used in your direct clinical management
- Services and supplies provided by the trial sponsor for free
- The experimental item, device or service itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies and described below)

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
- Published, peer reviewed scientific evidence you may benefit from the treatment

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

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

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

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens and injection aids
  - Test strips for blood glucose, ketone and urine monitoring, including visually readable strips
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Glucagon emergency kits
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
  - Foot orthotic devices including orthopedic shoes and shoe inserts
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Gender affirming treatment

Covered services include certain services and supplies for gender affirming treatment.

Covered services under this benefit include:

- The surgical procedure
- **Health professional** pre-operative and post-operative **hospital** and office visits
- Inpatient and outpatient services (including outpatient surgery)
- **Skilled nursing facility** care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiology services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled
- Gender affirming counseling by a **behavioral health provider**
- Injectable and non-injectable hormone replacement therapy

The following are not **covered services**:

- **Cosmetic** services and supplies, unless they are **medically necessary** for treatment of gender identity disorder or gender dysphoria. Services include, but are not limited to the following:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing
  - Chin implants, nose implants, and lip reduction

Important note:
Gender affirming treatment requires **precertification**. Your **network provider** is responsible for obtaining **precertification**. You are responsible for making sure that **precertification** is obtained if you are using an **out-of-network provider**. **Precertification** can be requested by either you or your **out-of-network provider**. Our clinical policy bulletin explains more about this care, **medical necessity** and limitations. Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for this information. You can also call the toll-free number on your ID card.

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 except for palliative care services
- Your **health professional** 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, palliative care 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**, other **health professional** 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

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** or other health professional 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

Jaw joint disorder treatment

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

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- 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 and surgical dental services related to **jaw joint disorder**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. This includes low risk delivery in a home setting [or birthing center] as determined by the attending health professional and complications of pregnancy. 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 **health professional**, with the consent of the mother, discharges the mother or newborn earlier

Covered services also include services and supplies needed for circumcision by a **provider**. Coverage for a newborn child will be the same as the child's mother for no less than 21 days.

The following are not **covered services**:

- Any place not licensed to perform deliveries except as described above for low risk deliveries in a home setting

Covered services also include the inpatient use of **medically necessary** donor human milk obtained from a milk bank when prescribed by a licensed **health professional** for an infant who is medically or physically unable to receive maternal breast milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal breast milk in sufficient quantities or caloric density or participate in chest feeding. Such infant must meet at least one of the following criteria:

- Infant birth weight of less than 2,500 grams
- Infant gestational age equal to or less than 34 weeks
- Infant hypoglycemia
- A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity
- A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications
- Congenital heart disease requiring surgery in the first year of life
- An organ or bone marrow transplant
- Sepsis
- Congenital hypotonias associated with feeding difficulty or malabsorption
- Renal disease requiring dialysis in the first year of life
- Craniofacial anomalies
- An immune deficiency
- Neonatal abstinence syndrome
- Any other serious condition or acquired condition for which the use of donor human milk derived products is **medical necessary** and supports the treatment and recovery of the child
- Any infant still inpatient within 72 hours of birth without sufficient breast milk available

Donor human milk means human milk that has been contributed to a milk bank by one or more donors.

Milk bank means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

Neurodevelopmental therapy services

Covered services include rehabilitative and habilitative speech, physical or occupational therapy, but only if it is expected to:

- Restore or improve speech or a body function
- Develop speech or a body function that was lost or delayed because of an illness or because of a condition you had when you were born
- Maintain speech or a body function that would get worse because of an illness or because of a condition you had when you were born

Nutritional support

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

Covered services include amino acid modified preparations, dietary specialized formulas and low protein modified food products ordered by a **health professional** for the treatment of inherited metabolic diseases including phenylketonuria or an inherited disease of amino and organic acids and eosinophilic gastrointestinal disorder.

The following are not **covered services**:
Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items

Prescription drugs - outpatient

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

Your prescription drug rights

You may contact us about your **prescription drug** benefits by calling the number on your ID card or visit www.aetna.com. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington state Office of the Insurance Commissioner at 800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or **pharmacies** serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

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

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section or just contact us.

You can find out if a **prescription** drug is covered; see the *Contact us* section. You may also go to https://www.aetna.com/individuals-families/find-a-medication.html.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

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

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

Prescription drug synchronization

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

Important note:
Certain **prescription** drug cost share paid directly by you or on your behalf may count toward your **deductible** and will count toward your **maximum out-of-pocket limit**, if you have one. Contact us for details.

Family planning services –contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **health professional** or other **provider** 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 prescribed, provided, administered, or removed by a **health professional**.
- Voluntary sterilization including charges billed separately by the **provider** for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation, vasectomy 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

Off-label use
U.S. Food and Drug Administration (FDA) approved prescriptions drugs may be covered when the off-label use of the drugs has not been approved by the FDA for your symptom(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.)
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
- Use for your symptom(s) is proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial is published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above.
  - The dosage is proven safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial is published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Mammograms

Covered services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis), supplemental and diagnostic breast examinations, which may include MRI, ultrasound or mammography

Telemedicine

Covered services include **telemedicine** consultations and **store and forward technology** when provided by a **physician**, **specialist**, **behavioral health provider, health professional** 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**:

- Emails
- Faxes
- **Store and forward technology** services for which there is no related **telemedicine** consultation or office visit with the **provider**

Surprise bill

There may be times when you unknowingly receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill. Review *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* that is attached to this certificate.

Complaints, claim decisions and appeal procedures

We previously explained how you and we share responsibility for paying for **covered services**. See the *Benefit payments and claims* section. When a claim comes in, we decide and tell you how you and we will split the expense. We also explain below what you can do if you think we got it wrong.

Important note: For language assistance, call us at the number on your ID card TTY:711 or visit: www.aetna.com/individuals-families/contact-aetna/information-in-other-languages.html. The hearing and speech impaired may call our toll-free TDD (Telecommunications Device for the Deaf) telephone number 1-800-628-3323. To serve visually impaired enrollees, Aetna's Voice Advantage is an automated, speech recognition system that is available 24 hours a day, 7 days a week. The content of materials may be read aloud to enrollees.

The difference between a grievance and an appeal

Grievance

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint or grievance. Your grievance should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the grievance. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination or adverse decision. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting 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 internal appeal. But in most situations, you must complete the appeal process before you can pursue arbitration, litigation or other type of administrative proceeding.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 72 hours for an urgent appeal and within 14 days or 20 days for experimental or investigational treatment for a pre-service appeal. We will let you know within 72 hours that we have received your appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 14 days or 20 days for experimental or investigational treatment for a post-service claim. We will let you know within 72 hours that we have received your appeal. For a pre-service or post-service claim, we may, for good cause, extend the time it takes to make a decision by up to 16 additional days if we notify you and provide a reason. If we need more time beyond the 16 additional days, we will ask for your written permission.

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

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

Exhaustion of appeal process

In most situations, you must complete the appeal process with us before you can pursue arbitration, litigation or other type of administrative proceeding.

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

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally. See the *Contact us* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of the Washington or of the federal Department of Health and Human Services. 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

At any time you may contact the Washington Office of the Insurance Commissioner at 800-562-6900 to request an investigation of a grievance or appeal.

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or unproven**

You may also request external review if you want to know if the federal and state surprise bill and balance bill law applies to your situation. See the section *Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State* at the end of this Certificate.

The notice of adverse benefit determination or final adverse benefit determination we send you 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 180 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any 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.

We will contact the ERO that will conduct the review of your claim.

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Accept additional written information from you for up to five business days after the ERO accepts its assignment
- 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 and timely implement its determination, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

We will give you the ERO decision not more than 30 calendar days after we receive your Request for External Review form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a Request for Expedited External Review form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse benefit determinations

- Your **provider** tells us a delay in 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)

For final adverse determinations

Your **provider** tells us a delay in 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.

Utilization review

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

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

Recordkeeping

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

Fees and expenses

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

Who can be a dependent on this plan

If your plan includes coverage for dependents, you can enroll the following family members:

- Your domestic partner who meets requirements under state law
- Dependent children – yours or your spouse's or domestic partner's
  - Dependent children must be:
    - Under 26 years of age

How can you extend coverage during a strike, lockout or other labor dispute?

You have a right to extend coverage for you and your dependents even if you are absent from work because of a strike, lockout or other labor dispute if:

- You were covered on the date you stopped working, and
- You paid your **premium** when due

You can continue your coverage for up to 6 months if you pay your **premiums** to your employer. Your employer will send your payment to us. Call the number on your ID card to get the process started. Your coverage will continue until:

- You go to work full-time for another employer
- You do not make the required **premium** payments
- The labor dispute ends, or
- The 6 months continuation period ends

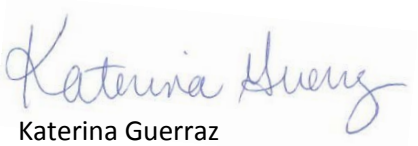
Your **premium** payment will be the same rate you were paying on the date you stopped working. But, if the **premium** amount your employer has to pay changes during the time you are extending your coverage, your **premiums** will also change.

You may elect to enroll in an individual plan by going to wahealthplanfinder.org when termination of your group coverage occurs.

Physician

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

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



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

Amendment: Washington Medical ET
Issue Date: April 24, 2026