BENEFIT PLAN

Prepared Exclusively for
HSP Southern Healthcare, LLC

Open Access Managed Choice Extraterritorial Riders

Extraterritorial Riders

Aetna Life Insurance Company

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

Table of Contents

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: HSP Southern Healthcare, LLC

Group policy number: GP-141582

Amendment effective date: August 1, 2020

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 Alabama. The benefits below will apply instead of those in your booklet-certificate.

Autism Spectrum Disorders (GR-9N 11-171 06)

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the screening, diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a **physician or a behavioral health provider;** and the covered expenses are incurred prior to attainment of age nineteen.

Coverage also includes certain early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Pharmacy Benefit Limitations *(GR-9N 13-015 07)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

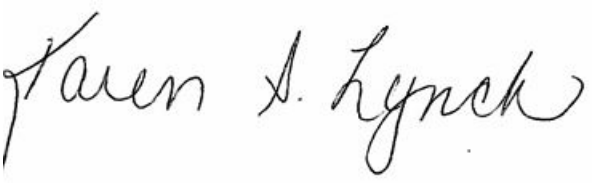
The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Alabama Medical ET
Issue Date: July 25, 2020

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: HSP Southern Healthcare, LLC

Group policy number: GP-141582

Amendment effective date: August 1, 2020

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 Maryland. The benefits below will apply instead of those in your booklet-certificate.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices;
- Provides medical services which are within the scope of his or her license or certificate.
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, or a **mental disorder**; and
- Is not you or related to you.

This also includes a licensed health professional who:

- Under applicable insurance law, are considered a "**physician**" for purposes of this coverage and;
- Are properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Have the medical training and clinical expertise suitable to treat your condition;
- Specialize in behavioral health, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, or a **mental disorder**; and
- Are not you or related to you.

1. The Habilitative services provision contained in the Other Services section of the Certificate is deleted and replaced in its entirety with the following:

Habilitation therapy services

Habilitation therapy services are services and devices, including occupational therapy, physical therapy and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living.

Covered expenses include habilitation therapy services for covered persons until the end of the month in which they turn 19 years of age, and that a **Physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **Hospital**, **Skilled Nursing Facility**, or **Hospice Facility**
- A **Home Health Care Agency**
- A **Physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by the covered person's **Physician**, that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in the covered person's home, if homebound

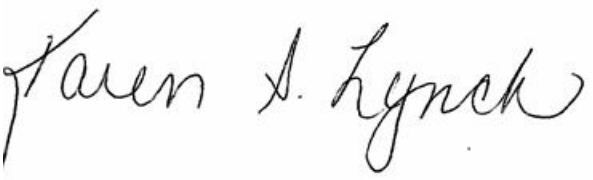
2. The Accident and Health Insurance Claims portion of the Reporting of Claims provision contained in the General Provisions section of your Certificate is deleted and replaced in its entirety with the following:

Accident and Health Insurance Claims

In addition to the above, a claim must be submitted to **Aetna** in writing within 1 year of the date of the loss. All claims must give proof of the nature and extent of the loss. Your employer has claim forms or you can request a claim form from **Aetna**. If you request and do not receive a claim from Aetna within 15 days after your request, you will have complied with the reporting of a claim requirement if you submit, within the time period noted, written proof of the occurrence, character, and extent of the loss for which the claim is made.

Aetna will not invalidate or reduce your claim if it is not reasonably possible for you to meet the deadline for filing your claim and notice was given as soon as reasonably possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

All other terms and conditions of the group policy shall remain in full force and effect except as amended herein.



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Amendment: Maryland Medical ET
Issue Date: July 25, 2020

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: HSP Southern Healthcare, LLC

Group policy number: GP-141582

Amendment effective date: August 1, 2020

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 Ohio. The benefits below will apply instead of those in your booklet-certificate.

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

Precertification requests for opioid treatment will be treated as an expedited service in accordance with applicable state and federal law.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

If you may be at risk for an adverse outcome or you have experienced an adverse outcome due to medication use, we can connect you with a nurse to navigate benefits and treatment plans. To talk to someone about treatment with opioids, or treatment for opioid addiction, call the Member Services number on your ID card.

Child Health Supervision Services *(GR-9N 11-005-01 OH)*

Covered expenses include charges for the periodic review of a child's physical and emotional status performed by a **physician** for a child from birth to age 9.

A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Anticipatory guidance.
- Development and behavioral assessment.
- Hearing screening.
- Vision and lead toxicity screening and immunizations.
- One series of hereditary and metabolic tests performed at birth.
- Urinalysis and blood tests such as hematocrit and hemoglobin tests.
- Counseling and guidance of the child and the child's parents or guardians on the results of the physical exam.

Child Health Supervision Services are limited to charges incurred at birth and approximately each of the following ages:

One month	12 months	4 years
2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	7 years
9 months	3 years	8 years

Child Health Supervision Services provided from birth to age 1 including hearing screening are covered up to the Birth to Age One Maximum.

Child Health Supervision Services thereafter are covered up to the Age One to Age Nine Calendar Year Maximum.

Hearing screenings are covered up to the Hearing Screening Maximum.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for Child Health Supervision Services.

Gatekeeper PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Child Health Supervision Services (From Birth to Age 9)	100% per exam No Calendar Year **deductible** applies.	50% per exam No Calendar Year **deductible applies.**
Child Health Supervision Services		
Birth to Age One Maximum	$500	$500
Birth to Age One - Hearing Screening Maximum	$75	$75
Age One to Age Nine - Calendar Year Maximum	$150	$150

Screening Mammography and Cytologic Screening *(GR-9N 11-005-01 OH)*

Covered expenses include charges for screening mammography to detect the presence of breast cancer in adult women and cytologic screening for the presence of cervical cancer.

Mammography screenings are covered up to:

- 1 screening for a woman age 35 but under age 40;
- 1 screening every 2 years for a woman age 40 but under age 50 or 1 every year if a physician has determined that the woman has risk factors to breast cancer;
- 1 screening every year for a woman age 50 or older but under age 65.

Cytologic screenings are covered up to every 12 month consecutive period.

The most that the plan will pay for each mammography screening is the Mammography Screening Maximum.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings *(GR-9N S-11-15 01 OH)*		
Routine Mammography	100% per test No Calendar Year **deductible** applies.	50% per test after Calendar Year **deductible**
Maximum visits	▪ 1 visit for females age 35 through 39 ▪ 1 visit every year for females age 40 and over	▪ 1 visit for females age 35 through 39 ▪ 1 visit every year for females age 40 and over
Mammography Screening Services Maximum	In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)	In no event will the Mammography Screening Maximum exceed 130% of the Medicare reimbursement rate for screening mammography. (Payment shall be made in full to the Provider, Hospital or other Health Care Facility, excluding approved **deductibles** and **copays**)

Pregnancy Related Expenses *(GR-9N 11-100 01 OH)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include the charges for post discharge follow-up care for a mother and her newborn ordered and supervised by a **physician**. Services related to maternity follow-up care are covered whether such services are provided in a medical setting or in the home.

If the mother is discharged earlier than the minimum lengths of stay indicated above, all follow-up care received within 72 hours after discharge is covered without regard to medical necessity.

If the mother receives at least the minimum number of hours of inpatient care shown above, follow-up care that is not medically necessary will not be covered.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Off-Label Use *(GR-9N 13-005 01 OH)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, at **Aetna's** sole discretion, be subject to **precertification**, **step-therapy** or other **Aetna** requirements or limitations.

Continuing Coverage After You Terminate Employment *(GR-9N 31-015-01 OH)*

You have the option to continue your and your dependent's health care benefits for up to 6 months if coverage would otherwise end because your employment ends.

You are eligible for this continuation but only if you:

- have been covered under the group policy for 3 months before employment ended;
- are entitled to unemployment compensation benefits when employment ended;
- are not or do not become covered or eligible for coverage by Medicare; and
- are not or do not become covered or eligible for comparable benefits under any other group or individual plan.

Your employer will notify you of this option at the time your employment ends and the amount of the contribution required.

You must elect continuation and pay the required contribution to the employer no later than the earlier of:

- 31 days after the date your coverage would otherwise terminate;
- 10 days after the date your coverage would otherwise terminate, if notice is given before that date; or
- 10 days following the date coverage would otherwise terminate, if notice is given after that date.

Coverage under this continuation will end on the first to occur of:

- You cease to be eligible for this continuation as shown above;
- 6 months following the date coverage would otherwise terminate due to termination of employment;
- You fail to make the required contribution; or
- The group policy terminates.

Coordination Disputes *(GR-9N 33-015 01 OH)*

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686- 1526.

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's coverage will continue as long as:

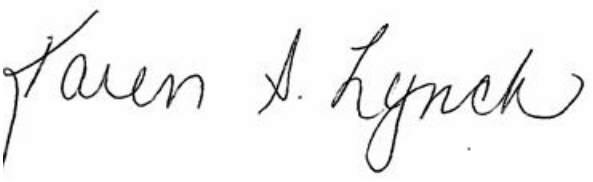
- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.



Karen S. Lynch
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(A Stock Company)

Amendment: Ohio Medical ET
Issue Date: July 25, 2020

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: HSP Southern Healthcare, LLC

Group policy number: GP-141582

Amendment effective date: August 1, 2020

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 Tennessee. The benefits below will apply instead of those in your booklet-certificate.

Clinical Trial Expenses *(GR-9N-11-094-01 TN)*

This plan will pay for the **medically necessary** and routine patient care **physician** and facility charges incurred by a person who is enrolled in a Phase I, Phase II, Phase III or Phase IV Clinical Trial study. A "clinical trial" means a patient research study that is designed to evaluate a new drug, medical device, or service that falls within a Medicare benefit category and is not statutorily excluded from coverage. Such proposed treatment:

- must be intended to treat cancer;
- must have therapeutic intent; and
- must be recommended by the person's treating **physician** as having meaningful potential benefit to the person based upon at least two documents of medical and scientific evidence.

The clinical trial must meet the following criteria:

- It must involve a drug that is exempt under federal regulations from new drug application.
- It must be approved by centers or cooperative groups that are funded and sponsored by the National Institutes of Health, the Food and Drug Administration (FDA) in the form of an investigational new drug application, the Department of Defense, or the Department of Veterans Affairs.

Charges for **covered expenses** incurred by a person for:

- health care services for the appropriate monitoring of the person during the clinical trial; and
- the treatment;
- provided in the clinical trial; and
- that is a result of unintended medical complications caused by the treatment provided in the clinical trial;

are payable on the same basis as any illness or injury covered under this Plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including, but not limited to:

- **Aetna's** Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Covered expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to **precertification** and referral requirements.

Limitations
Unless specified above, the clinical trial benefit does ***not*** cover charges for:

- any drug, device, or service that is not approved by the FDA and that is associated with the clinical trial; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research;
- any expenses related to participation in the clinical trial, including travel, housing, and other expenses;
- any expenses incurred by a person accompanying the person; and
- any expenses related to determining eligibility for participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the person.

Off-Label Use *(GR-9N-11-110-01 TN)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification, step-therapy** or other **Aetna** requirements or limitations.

Recovery of Overpayments *(GR-9N-32-015-01 TN)*

Health Coverage

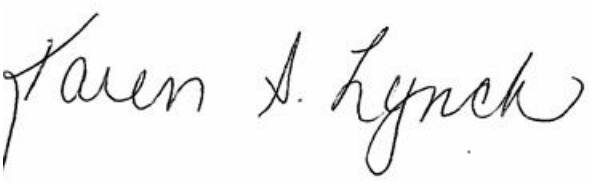
If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right will not apply more than 15 months as to you and 18 months as to a health care provider after the overpayment was made unless:

- the overpayment was made due to failure to provide complete information, fraud or material misstatements (on the part of you or the health care provider); or
- you or the health care provider has otherwise agreed to return the overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.



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Amendment: Tennessee Medical ET
Issue Date: July 25, 2020