BENEFIT PLAN

Prepared Exclusively For
Outten & Golden, LLP

Aetna Vision Preferred

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

This is Your

Preferred Provider Organization Certificate of Coverage

Issued by

Aetna Life Insurance Company

Prepared exclusively for:

Policyholder:	Outten & Golden, LLP
Group policy number:	GP-0149284-D
Group policy effective date:	January 1, 2020
	Booklet-certificate 1
Plan issue date:	November 10, 2021
Plan revision effective date	January 1, 2022

This certificate of coverage ("**certificate**") explains the benefits available to you under a group policy between Aetna Life Insurance Company (hereinafter referred to as "we", "us", or "our") and the group listed in the group policy. This certificate is not a contract between you and us. Amendments, riders or endorsements may be delivered with the certificate or added thereafter.

This certificate offers you the option to receive **covered services** on two benefit levels:

1. **In-network benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when your care is provided by **participating providers** in-network. You should always consider receiving **eligible vision services** first through the in-network benefits portion of this **certificate**.

2. **Out-of-network benefits.** The out-of-network benefits portion of this certificate provides coverage when you receive **covered services** from **non-participating providers**. Your out-of-pocket expenses will be higher when you receive out-of-network benefits. You may have to pay for **eligible vision services** at the time that they are provided. You [may] be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible vision services** that you paid directly to a vision **provider**. In addition to **cost-sharing**, you will also be responsible for paying any difference between the **allowed amount** and the **non-participating provider's** charge.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This **certificate** is governed by the laws of New York State.

The insurance evidenced by this certificate provides VISION insurance ONLY.

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.aetna.com
- Registering for our secure Internet access to reliable vision information, tools and resources

Online tools will make it easier for you to make informed decisions about your vision care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling **Aetna** Member Services at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card
Your member ID card tells **vision providers** that you are covered by this plan. Show your ID card each time you get vision care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven't received it before you need **eligible vision services**, or if you've lost it, you can print a temporary ID card. Just log into your secure member website at www.aetna.com.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Table of Contents

SECTION I: Definitions

Defined terms will appear bolded throughout the **certificate**.

Aetna
Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with **Aetna**.

Allowed amount
The maximum amount on which our payment is based for **covered eligible vision services**. For **participating providers** this is based on a **negotiated charge** for a **covered eligible vision service**, or in the case of a **non-participating provider** on the **recognized charge**.

Appeal
A request for us to review a **utilization review** decision or a **grievance** again.

Calendar year
A period of 12 months that begins on January 1st and ends on December 31st.

Certificate
This **certificate** issued by Aetna Life Insurance Company and any attached riders. The **certificate** explains the benefits available to you under the **group policy**.

Child, children
The **subscriber's children**, including any natural, adopted or step-children, unmarried disabled **children**, newborn **children**, or any other **children** as described in the *Who is Covered* section of this **certificate**.

Coinsurance
Your share of the costs of a **covered eligible vision service**, calculated as a percent of the **allowed amount** for the service that you are required to pay to a **provider**. The amount can vary by the type of **covered eligible vision service**.

Copay, copayments
The dollar or percentage amount you pay to an **in-network provider** for an **eligible vision service**.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Cost-sharing
Amounts you must pay for covered services, expressed as copayments, deductibles, and/or coinsurance.

Dependents
The subscriber's spouse and children.

Directory
The list of **participating providers** for your plan. The most up-to-date **directory** for your plan appears at www.aetna.com. When searching your member website, you need to make sure that you are searching for providers that participate in your specific plan. **Participating providers** may only be considered for certain **Aetna** plans. When searching for network **vision providers**, you need to make sure you are searching under vision plan.

Effective date of coverage
The date you and your dependent's coverage begins under this booklet-certificate as noted in our records.

Eligible vision services
The vision care services and supplies listed in the *Vision care* section and not listed or limited in the *Exclusions and limitations* section or in the schedule of benefits.

Exclusions
Vision care services that we do not pay for or cover.

External Appeal Agent
An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Grievance
A complaint that you communicate to us that does not involve a utilization review determination.

Group
The employer or party that has entered into an agreement with us as a **policyholder**.

Group policy
The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy**, the booklet-certificate, and the schedule of benefits

In-network copayment
A fixed amount you pay directly to a participating provider for a covered service when you receive the service. The amount can vary by the type of covered service.

Lifetime maximum allowance
This is the most the plan will pay for all charges you incur during your lifetime for an **eligible vision service** provided by an **in-network provider**.

Maximum allowance
This is the most the plan will pay for an **eligible vision service** provided by an **in-network provider**.

Medically Necessary
See the *How your coverage works* section of this certificate for the definition.

Medicare
Title XVIII of the Social Security Act, as amended.

Member
The subscriber or a covered dependent for whom required premiums have been paid. Whenever a member is required to provide a notice, "member" also means the member's designee.

Non-participating provider
A provider who doesn't have a contract with us to provide services to you. You will pay more to see a non-participating provider.

Out-of-network copayment
A fixed amount you pay directly to a non-participating provider for a covered service when you receive the service. The amount can vary by the type of covered service.

Participating provider
A **provider** who has a contract with us to provide services to you. A list of **participating providers** and their locations is available on our website at www.aetna.com or upon your request to us. The list will be revised from time to time by us.

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice, specifically, doctors of medicine or osteopathy.

Policyholder
An employer or organization who agrees to remit the **premiums** for coverage under the **group policy** payable to **Aetna**. The **policyholder** shall act only as an agent of **Aetna members** in the employer group, and shall not be the agent of **Aetna** for any purpose.

Preauthorization
A decision by us prior to your receipt of a covered service, procedure, treatment plan, or device that the covered service, procedure, treatment plan, or device is medically necessary. We indicate which covered services require preauthorization in the schedule of benefits section of this **certificate**.

Premium
The amount you or your **policyholder** are required to pay to **Aetna** for your coverage.

Prescription
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Schedule of benefits
The section of this certificate that describes the copayments, out-of-pocket limits, preauthorization requirements, and other limits on covered services.

Scheduled limit
The most the plan will reimburse for vision services incurred by any one covered person from a Non-Participating Provider. You are responsible for any charges above the scheduled limit.]

Spouse
The person to whom the subscriber is legally married, including a same sex spouse. Spouse also includes a domestic partner.

Subscriber
The person to whom this certificate is issued.

Us, We, Our
Aetna Life Insurance Company and anyone to whom we legally delegate performance, on our behalf, under this certificate.

Utilization Review
The review to determine whether services are or were medically necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

Vision provider
Any individual legally licensed to provide vision services or supplies.

You, Your
The member.

SECTION II: How your coverage works

Your coverage under this certificate

Your employer (referred to as the "**group**") has purchased a group vision insurance policy from us. We will provide the benefits described in this **certificate** to covered **members** of the **group**, that is, to employees of the **group** and/or their covered **dependents**. However, this **certificate** is not a contract between you and us. You should keep this **certificate** with your other important papers so that it is available for your future reference.

Covered services

You will receive **covered eligible vision services** under the terms and conditions of this **certificate** only when the **covered eligible vision service** is:

- **Medically necessary**;
- Provided by a **participating provider** for in-network coverage;
- Listed as a **covered eligible vision service**;
- Not in excess of any benefit limitations described in the *Vision care* section of this **certificate**; and
- Received while your **certificate** is in force.

Participating providers

We have contracted with vision **providers** to provide **eligible vision services** to you. These vision **providers** make up the network for your plan. For you to receive the network level of benefits you must use **participating providers** for **eligible vision services**.

To find out if a **provider** is a **participating provider**:

- Check your **provider directory**, available at your request;
- Call 1-877-238-6200; or
  Visit our website at www.aetna.com and search our online **directory** for names and locations of **participating providers**.

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

The role of the vision providers

You are encouraged to receive care from a **participating provider**.

Access to providers and changing providers

Sometimes **providers** in our **provider directory** are not available. You should call the **provider** to make sure he or she is a **participating provider** and is accepting new patients.

To see a **provider**, call his or her office and tell the **provider** that you are an **Aetna member,** and explain the reason for your visit. The **provider's** office may ask you for your **group** or **Member** ID number.

You have the freedom to choose a **vision provider** who is not in the vision network. Your plan often will pay a bigger share for **eligible vision services** that you get through a **participating provider**.

Out-of-network services

You have coverage when you want to get your care from **providers** who are not part of the **Aetna** network under your plan. It's called out-of-network coverage.

Your out-of-network coverage:

- Means you may have to pay for services at the time they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible vision services** that you paid directly to a **provider**.
- Means you will pay a higher cost share when you use a **non-participating provider**.

Services subject to preauthorization

Our preauthorization is not required before you receive certain **covered services**.

Medical management

The benefits available to you under this Certificate may be subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by us. The purpose of these reviews is to promote the delivery of cost-effective care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed.

Medical necessity

We cover benefits described in this Certificate as long as the vision service, procedure, treatment, test, device, or supply (collectively, "service") is **medically necessary**. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it medically necessary or mean that we have to cover it.

We may base our decision on a review of:

- Your vision records;
- Our vision policies and clinical guidelines;
- Vision opinions of a professional society, peer review committee or other groups of physicians;
- Reports in peer-reviewed vision literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending providers, which have credence but do not overrule contrary opinions.

Services will be deemed **medically necessary** only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- They are provided in accordance with generally-accepted standards of vision practice;
- They are not primarily for the convenience of you, your family, or your provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results.

See the *Utilization review* and *External appeal* sections of this **certificate** for your right to an internal appeal and external appeal of our determination that a service is not **medically necessary**.

Important telephone numbers and addresses

- CLAIMS
  Refer to the address on Your ID card
  (Submit claim forms to this address.)

  www.aetna.com
  (Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Call the number on Your ID card

- MEMBER SERVICES
  Call the number on Your ID card
  (Member Services Representatives are available Monday – Friday 8:00 a.m. – 6:00 p.m.)

- OUR WEBSITE
  www.aetna.com

SECTION III: Cost-sharing expenses and allowed amount

Deductible

There is no **deductible** for **covered** in-network and out-of-network **eligible vision services** under this **certificate** during each **plan year**.

Copayments

Your **copayment** is the amount you pay for **eligible vision services**. Except where stated otherwise, you must pay the **copayments**, or fixed amounts, in the schedule of benefits section of this **certificate** for specific **eligible vision services**. However, when the allowed amount for a service is less than the copayment, you are responsible for the lesser amount.

Coinsurance

There is no **coinsurance** for covered services under this **certificate**.

Allowed Amount

Allowed amount means the maximum amount we will pay for the services or supplies covered under this **certificate**, before any applicable copayment amounts are subtracted. We determine Our Allowed Amount as follows:

The **allowed amount** for participating providers will be the amount we have negotiated with the participating provider.

Special financial responsibility

You are responsible for the entire expense of Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage

SECTION IV: Who is covered

Who is eligible
Your **policyholder** decides and tells us who is eligible for vision care coverage.

Who is covered under this certificate
You, the **subscriber** to whom this **certificate** is issued, are covered under this **certificate**. If your plan includes coverage for dependents, members of your family may also be covered depending on the type of coverage you selected.

Effective date of coverage
Your coverage will be in effect on the first date of the month based on when we receive your completed enrollment application.

Types of coverage
We offer the following types of coverage:

- Individual - If you selected individual coverage, then you are covered.
- Individual and **spouse** - If you selected individual and **spouse** coverage, then you and your **spouse** are covered.
- Parent and **child(ren)** - If you selected parent and **child(ren)** coverage, then you and your **child** or **children**, as described below, are covered.
- Family - If you selected family coverage, then you and your **spouse** and your **child** or **children**, as described below, are covered.

Children covered under this certificate
If you selected parent and **child(ren)** or family coverage, **children** covered under this **certificate** include your:

- Natural **children**
- Legally adopted **children**
- Step-**children**
- **Children** for whom you are the proposed adoptive parent without regard to financial dependence, residency with you, student status or employment
- Foster **children**
- **Children** you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
- Grandchildren in your court-ordered custody
- A grand**child** whose parent is already covered as a **dependent** under this plan
- Any other **child** with whom you have a parent-child relationship

A proposed adopted **child** is eligible for coverage on the same basis as a natural **child** during any waiting period prior to the finalization of the **child's** adoption.

Coverage lasts until the day in which the **child** turns 26 years of age.

Any unmarried **dependent child**, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the **child's** coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance, will remain covered while your insurance remains in force and your **child** remains in such condition.

You have 31 days from the date of your **child's** attainment of the termination age to submit an application to request that the **child** be included in your coverage and proof of the **child's** incapacity. We have the right to check whether a **child** is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered subscriber and all other prospective or covered members in relation to eligibility for coverage under this certificate at any time.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered **subscriber** and all other prospective or covered members in relation to eligibility for coverage under this **certificate** at any time.

When coverage begins

Coverage under this **certificate** will begin as follows:

As an employee you can enroll yourself and your **dependents**:

- At the end of any waiting period the policyholder requires
- At any time
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special enrollment period* section below)

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your **policyholder** when benefits for your spouse will begin:
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If we received your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be a dependent)* section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your **policyholder**.
  - Ask your **policyholder** when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.

- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child - – this includes a proposed adoptive child during any waiting period prior to the finalization of the child's adoption.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.
- A foster child – A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask your **policyholder** when benefits for your stepchild will begin. It is the date of your marriage or Declaration of Domestic Partnership or the first day of the month following the qualifying event date.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group vision plan

Special times you and your dependents can join the plan

You can enroll in these situations when:

- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You become a citizen, national or lawfully present in the United States.
- You did not enroll in this plan before because:
  - You were covered by another group vision plan, and now that other coverage has ended
  - You had COBRA, and now that coverage has ended
- A court orders you cover a current spouse, domestic partner or a child on your vision plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above.

Your coverage will be in effect on the first date of the month based on when we receive your completed enrollment application.

Domestic partner coverage

This **certificate** covers domestic partners of **subscribers** as **spouses**. If you selected family coverage, **children** covered under this **certificate** also includes the **children** of your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

- Registration as a domestic partnership indicating that neither individual has been registered as a **member** of another domestic partnership within the last six (6) months, where such registry exists; or
- For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
  - The affidavit must be notarized and must contain the following:
    - The partners are both 18 years of age or older and are mentally competent to consent to contract;
    - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
    - The partners have been living together on a continuous basis prior to the date of the application;
    - Neither individual has been registered as a **member** of another domestic partnership within the last six (6) months; and
  - Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
  - Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
    - A joint bank account;
    - A joint credit card or charge card;
    - Joint obligation on a loan;
    - Status as an authorized signatory on the partner's bank account, credit card or charge card;
    - Joint ownership of holdings or investments;
    - Joint ownership of residence;
    - Joint ownership of real estate other than residence;
    - Listing of both partners as tenants on the lease of the shared residence;
    - Shared rental payments of residence (need not be shared 50/50);
    - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
    - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
    - Shared household budget for purposes of receiving government benefits;
    - Status of one (1) as representative payee for the other's government benefits;
    - Joint ownership of major items of personal property (e.g., appliances, furniture);
    - Joint ownership of a motor vehicle;
    - Joint responsibility for child care (e.g., school documents, guardianship);
    - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
    - Execution of wills naming each other as executor and/or beneficiary;
    - Designation as beneficiary under the other's life insurance policy;

- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION V: Vision care

Eligible vision services include services provided by an ophthalmologist or optometrist.

You may get vision services and supplies from any **vision providers** in our network. Your out-of-pocket costs will usually be lower when you use **participating providers**. Some services and supplies may only be covered when provided by a **participating provider**. Refer to your schedule of benefits for more information.

You may use **out-of-network vision providers** of your choice for covered vision services and supplies under this plan. Your costs will be higher when you use **vision providers** who are not in our network.

Eye exam

Eligible vision services include:

- Routine/comprehensive eye exam by an ophthalmologist or optometrist to diagnose or identify existing conditions of the eye or vision. This includes:
  - Case history
  - General patient observation
  - Clinical and diagnostic testing and evaluation, including dilation
  - Refraction
  - Color vision testing
  - Stereopsis testing
  - Case presentation

Vision care services and supplies

Eligible vision services and supplies include those prescribed for the first time, emergency care and those required because of a change in **prescription**. These include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses that are identified by a **vision provider**
- Non-conventional **prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses or Aphakic **prescription** lenses prescribed after cataract **surgery** has been performed

In any one 12 consecutive month period, this benefit will cover **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

SECTION VI: Exclusions and limitations

We already told you about the many vision care services and supplies that are eligible for coverage under your plan in the *Vision care* section. In that section, we also told you that some vision care services and supplies have exclusions.

As a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

No coverage is available under this **certificate** for the following:

Cosmetic services and plastic surgery

- Any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Diabetic care

- Costs associated with securing frames, lenses, or any related vision supplies
- Orthoptics or vision training and any associated supplemental testing
- Surgical procedures, including laser or any other form of refractive surgery, and any pre- operative or post-operative services
- Pathological treatment of any type for any condition
- Any eye examination required by an employer as a condition of employment
- Insulin or any medications or supplies of any type
- Services and supplies not included in this plan

Examinations

Any vision examinations needed:

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

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

Orthoptics a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision

Other primary payer

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

Personal care, comfort or convenience items

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

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law

Services, supplies and drugs received outside of the United States

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

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care services and supplies

- Orthoptic or vision training
- Low vision exams, testing and aids, unless coverage is stated as covered in the *Eligible vision services under your plan* section of your booklet-certificate
- Aniseikonic lenses
- Medical and surgical procedure treatments of the eye, eyes, or supporting structures
- Any eye or vision examination or any corrective eyewear required by an employer or the **policyholder** as a condition of employment
- Safety glasses
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-**prescription**) lenses, includes contact lenses
- Non-**prescription** sunglasses
- Two pair of glasses instead of bifocals
- Services provided after the date you're no longer covered under the plan, except for vision materials that:
  - Were ordered before coverage ended
  - Are delivered and **eligible vision services** are provided to you for the ordered materials within 31 days from the date of the order
- Services or materials provided by any other group benefit plan providing vision care
- Replacement of lost or broken lenses, frames, glasses or contact lenses (except in the next benefit period when you can order new ones)

SECTION VII: Claim determinations

Claims

A claim is a request that benefits or services be provided or paid according to the terms of this **certificate**. When you receive services from a **participating provider**, you will not need to submit a claim form. However, if you receive services from a **non-participating provider**, either you or the **provider** must file a claim form with us. If the **non-participating provider** is not willing to file the claim form, you will need to file it with us. See the *Coordination of benefits* section of this **certificate** for information on how we coordinate benefit payments when you also have coverage with another plan.

Notice of claim

You must provide us with your claim within 20 days after the procedure or loss covered by the policy. Failure to give notice within that time will not invalidate or reduce any claim if you show that it was unreasonable to give notice within that time and you give notice as reasonably possible.

Claims for services must include all information designated by us as necessary to process the claim, including, but not limited to:

- **Member** identification number
- Name
- Date of birth
- Date of service
- Type of service
- The charge for each service
- Procedure code for the service as applicable
- Diagnosis code
- Name and address of the **provider** making the charge; and
- Supporting medical records, when necessary

A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from us by calling 1-877-238-6200, or visiting our website at www.aetna.com. We will send the claim form to you within 15 days. If we do not provide you with a claim form within 15 calendar days, you will have complied with any requirements to submit proofs of loss. Completed claim forms should be sent to the address in the *How your coverage works* section of this **certificate**.

Timeframe for filing claims

Claims for services must be submitted to us for payment within 120 days after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, you must submit it as soon as reasonably possible.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible.

Claims for prohibited referrals

We are not required to pay any claim, bill or other demand or request by a **provider** for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

Claim determinations

Our claim determination procedure applies to all claims that do not relate to a **medical necessity** or **experimental or investigational** determination. For example, our claim determination procedure applies to contractual benefit denials. If you disagree with our claim determination, you may submit a **grievance** pursuant to the *Grievance procedures* section of this **certificate**.

For a description of the **utilization review** procedures and **appeal** process for **medical necessity** or **experimental or investigational** determinations, see the *Utilization review and External appeal* sections of this **certificate**.

Pre-service claim determinations

A pre-service claim is a request that a service or treatment be approved before it has been received. If we have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), we will make a determination and provide notice to you (or your authorized representative) within 15 days from receipt of the claim.

If we need additional information, we will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If we receive the information within 45 days, we will make a determination and provide notice to you (or your authorized representative) in writing, within 15 days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period.

Urgent pre-service reviews

With respect to urgent pre-service requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your authorized representative) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If we need additional information, we will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your authorized representative) by telephone within 48 hours of the earlier of the earlier of our receipt of the information of the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

Post-service claim determinations

A post-service claim is a request for a service or treatment that you have already received. If we have all information necessary to make a determination regarding a post-service claim, we will make a determination and notify you (or your authorized representative) within 30 calendar days of the receipt of the claim if we deny the claim in whole or in part. If we need additional information, we will request it within 30 calendar days. You will then have 45 calendar days to provide the information.

We will make a determination and provide notice to you (or your authorized representative) in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period if we deny the claim in whole or in part.

Payment of claims

Where our obligation to pay a claim is reasonably clear, we will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If we request additional information, we will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION VIII: Grievance procedures

Grievances

Our **grievance** procedure applies to any issue not relating to a **medical necessity** or **experimental or investigational** determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to **providers**.

Filing a grievance

You can contact us by phone at 1-877-238-6200 or in writing to file a **grievance**. You may submit an oral **grievance** in connection with a denial of a **covered** benefit determination. We may require that you sign a written acknowledgement of your oral **grievance**, prepared by us. You or your authorized representative has up to 180 calendar days from when you received the decision you are asking us to review to file the **grievance**.

When we receive your **grievance**, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your **grievance**, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited **grievances**, depending on the nature of your inquiry.

Grievance determination

Qualified personnel will review your **grievance**, or if it is a clinical matter, a licensed, certified or registered **health care professional** will look into it. We will decide the **grievance** and notify you within the following timeframes:

Expedited/urgent **grievances**:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your **grievance**.
Pre-service **grievance**: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of your **grievance**.
Post-service **grievances**: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of your **grievance**.
All other **grievances**: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of your **grievance**.

Grievance appeals

If you are not satisfied with the resolution of your **grievance**, you or your authorized representative may file an **appeal** by phone at 1-877-238-6200 or in writing. You have up to 60 business days from receipt of the **grievance** determination to file an **appeal**.

When we receive your **appeal**, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your **appeal** and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the **grievance** determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will make a decision on the **appeal** and notify you in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of your a**ppeal**.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of your **appeal**.
Post-service **grievances**: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of your **appeal**.
All other **grievances**: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

Assistance

If you remain dissatisfied with our **appeal** determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If you need assistance filing a **grievance** or **appeal**, you may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION IX: Utilization review

Utilization review

We review **eligible vision services** to determine whether the services are or were **medically necessary** or **experimental or investigational** ("**medically necessary**"). This process is called **utilization review**. **Utilization review** includes review of activities after the service is performed (retrospective). Under this **certificate**, we only review activities after the service is performed. If you have any questions about the **utilization review** process, please call 1-877-238-6200. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that **eligible vision services** are not **medically necessary** will be made by:

- Licensed **physicians**; or
- Licensed, certified, registered or credentialed **health care professionals** who are in the same profession and same or similar specialty as the **provider** who typically manages your vision condition or disease or provides the vision care service under review.

We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not **medically necessary**. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, call 1-877-238-6200 or visit our website at www.aetna.com.

Preauthorization Reviews

Non-Urgent Preauthorization Reviews: If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone and in writing, within three (3) business days of receipt of the request.

If we need additional information, we will request it within three (3) business days. You or your **provider** will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone and in writing, within three (3) business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45 day period.

Urgent Preauthorization Reviews: With respect to urgent Preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within 24 hours. You or your **provider** will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your authorized representative) and your **provider** by telephone within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. Written notification will be provided within the earlier of three (3) business days of our receipt of the information or three (3) calendar days after the verbal notification.

Concurrent Reviews

Non-Urgent Concurrent Reviews: Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your authorized representative) and your **provider**, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your **provider** will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your authorized representative) and your **provider**, by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

Urgent Concurrent Reviews: For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you (or your authorized representative) and your **provider** by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to you (or your authorized representative) and your **provider** within the earlier of 72 hours or of one (1) business day of receipt of the request. If we need additional information, we will request it within 24 hours. You or your **provider** will then have 48 hours to submit the information. We will make a determination and provide written notice to you (or your authorized representative) and your **provider** within the earlier of one (1) business day or 48 hours of our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

Retrospective reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your **provider** within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your **provider** will then have 45 calendar days to provide the information.

We will make a determination and provide notice to you and your **provider** in writing within 15 calendar days of the earlier of our receipt of all or part of the requested information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a **utilization review** determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal **appeal**.

Reconsideration

If we did not attempt to consult with your **provider** who recommended the **Covered eligible vision service** before making an adverse determination, the **provider** may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. If the adverse determination is upheld, a notice of adverse determination will be given to you and your **provider**, by telephone and in writing.

Utilization review internal appeals

You, your authorized representative, and, in retrospective review cases, your **provider**, may request an internal **appeal** of an adverse determination, either by phone or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an **appeal**.

We will acknowledge your request for an internal **appeal** within 15 calendar days of receipt.
This acknowledgment will, if necessary, inform you of any additional information needed before a decision can be made. The **appeal** will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is:

- A **physician**; or
- A **health care professional** in the same or similar specialty as the **provider** who typically manages the disease or condition at issue.

Preauthorization appeal

- If your **appeal** relates to a preauthorization request, we will decide the **appeal** within 30 calendar days of receipt of the **appeal** request.
- Written notice of the determination will be provided to you (or your authorized representative), and where appropriate, your **provider**, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

Retrospective appeal

- If your **appeal** relates to a retrospective claim, we will decide the **appeal** within 60 calendar days of receipt of the **appeal** request.
- Written notice of the determination will be provided to you (or your authorized representative), and where appropriate, your **provider**, within 2 business days after the determination is made, but no later than 60 calendar days after receipt of the **appeal** request.

Expedited appeal

- An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis.
- An expedited appeal is not available for retrospective reviews.
- For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax.
- An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

Full and fair review of an appeal

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us or any new or additional rationale in connection with your appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Appeal assistance

If you need assistance filing an **appeal**, you may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or email cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION X: External appeal

Your right to an external appeal

In some cases, you have a right to an external **appeal** of a denial of coverage. If we have denied coverage on the basis that a service is not **medically necessary** (including appropriateness, health care setting, level of care or effectiveness of a **covered** benefit); or is an **experimental or investigational** treatment (including clinical trials and treatments for rare diseases), you or your authorized representative may appeal that decision to an **external appeal agent**, an independent third party certified by the State to conduct these **appeals**.

In order for you to be eligible for an external **appeal** you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a **covered eligible vision service** under this **certificate**; and
- In general, you must have received a final adverse determination through our internal **appeal** process. But, you can file an external **appeal** even though you have not received a final adverse determination through our internal **appeal** process if:
  - We agree in writing to waive the internal **appeal**. We are not required to agree to your request to waive the internal **appeal**; or
  - We fail to adhere to **utilization review** claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

Your right to appeal a determination that an eligible vision service is not medically necessary

If we have denied coverage on the basis that the service is not **medically necessary**, you may **appeal** to an **external appeal agent** if you meet the requirements for an external **appeal** as described above.

Your right to appeal a determination that an eligible vision service is experimental or investigational

If we have denied coverage on the basis that the **eligible vision service** is an **experimental or investigational** treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external **appeal** as described above and your attending **physician** must certify that your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure covered by us; or
- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending **physician** must have recommended one of the following:

- A service, procedure or treatment that 2 documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard **covered eligible vision service** (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending **physician** certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending **physician** must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending **physician** must be a licensed, board-certified or board eligible **physician** qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending **physician** may not be your treating **physician**.

The external appeal process

You have 4 months from receipt of a final adverse determination or from receipt of a waiver of the internal **appeal** process to file a written request for an external **appeal**. If you are filing an external **appeal** based on our failure to adhere to claim processing requirements, you have 4 months from such failure to file a written request for an external **appeal**.

We will provide an external **appeal** application with the final adverse determination issued through our internal **appeal** process or our written waiver of an internal **appeal**. You may also request an external **appeal** application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external **appeal**, the State will forward the request to a certified **external appeal agent**.

You can submit additional documentation with your external **appeal** request. If the **external appeal agent** determines that the information you submit represents a material change from the information on which we based our denial, the **external appeal agent** will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have 3 business days to amend or confirm our decision. Please note that in the case of an expedited external **appeal** (described below), we do not have a right to reconsider our decision.

In general, the **external appeal agent** must make a decision within 30 days of receipt of your completed application. The **external appeal agent** may request additional information from you, your **physician**, or us. If the **external appeal agent** requests additional information, it will have 5 additional business days to make its decision. The **external appeal agent** must notify you in writing of its decision within 2 business days.

If your attending **physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending **physician** certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external **appeal**. In that case, the **external appeal agent** must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must notify you and us by telephone or facsimile of that decision. The **external appeal agent** must also notify you in writing of its decision.

If the **external appeal agent** overturns our decision that a service is not **medically necessary** or approves coverage of an **experimental or investigational** treatment, we will provide coverage subject to the other terms and conditions of this **certificate**. Please note that if the **external appeal agent** approves coverage of an **experimental or investigational** treatment that is part of a clinical trial, we will only **cover** the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be **covered** under this **certificate** for non-investigational treatments provided in the clinical trial.

The **external appeal agent's** decision is binding on both you and us. The **external appeal agent's** decision is admissible in any court proceeding.

Your responsibilities

It is your responsibility to start the external **appeal** process. You may start the external **appeal** process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within 4 months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XI: Coordination of benefits (COB)

This section applies when you also have group vision coverage with another plan. When you receive a **covered eligible vision service**, we will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

Definitions

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

An "allowable expense" is:

- The necessary, reasonable, and customary item of expense for vision care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

A "plan" is:

- Other group vision coverage with which we will coordinate benefits.
- The term "plan" includes:
  - Group vision benefits and blanket or group remittance vision benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
  - Vision benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
  - Vision benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

A "Primary plan" is:

- One whose benefits must be determined without taking the existence of any other plan into consideration.
- A plan is primary if either:
  - The plan has no order of benefits rules or its rules differ from those required by regulation; or
  - All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

A "secondary plan" is:

- One which is not a primary plan.
- If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to determine order of payment

The first of the rules listed in the paragraphs below that applies will determine which plan will be primary:

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the **subscriber** and is only covered as a **dependent** under the other plan, this **certificate** will be primary.
- If a **child** is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a **child** is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the **child's** vision care expenses:
  - The plan of the parent who has custody will be primary;
  - If the parent with custody has remarried, and the **child** is also covered as a **child** under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
  - If a court decree between the parents says which parent is responsible for the **child's** vision care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
- If a **child** is covered by an individual who is not a parent (i.e. stepparent or grandparent), treat the person the same as a parent when making the order of benefits determination.
- If the person receiving services is covered under one plan as an active employee or **member** (i.e., not laid-off or retired), or as the **spouse** or **child** of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the **spouse** or **child** of such a laid-off or retired employee, the plan that covers such person as an active employee or **spouse** or **child** of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed our maximum available benefit for each **covered eligible vision service**. Also, the amount we pay will not be more than the amount we would pay if we were primary. As each claim is submitted, we will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to receive and release necessary information

We may release or receive information that we need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give us any needed information for coordination purposes, in the time frame requested.

Our right to recover overpayment

If we made a payment as a primary plan, you agree to pay us any amount by which we should have reduced our payment. Also, we may recover any overpayment from the primary plan or the **provider** receiving payment and you agree to sign all documents necessary to help us recover any overpayment.

Coordination with “always excess,” “always secondary,” or “non-complying” plans

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this **certificate** is primary, as defined in this section, we will pay benefits first.
- If this **certificate** is secondary, as defined in this section, we will pay only the amount we would pay as the secondary insurer.
- If we request information from a non-complying plan and do not receive it within 30 days, we will calculate the amount we should pay on the assumption that the non-complying plan and this **certificate** provide identical benefits. When the information is received, we will make any necessary adjustments.

SECTION XII: Termination of coverage

Coverage under this **certificate** will automatically be terminated on the first of the following to apply:

- The **group** and/or **subscriber** has failed to pay **premiums** within 30 days of when **premiums** are due. Coverage will terminate as of the last day for which **premiums** were paid.
- The date on which the **subscriber** ceases to meet the eligibility requirements as defined by the **group**.
- Upon the **subscriber's** death, coverage will terminate unless the **subscriber** has coverage for **dependents**. If the **subscriber** has coverage for **dependents**, then coverage will terminate as of the last day of the month for which the **premium** has been paid.
- For **spouses** in cases of divorce, the date of the divorce.
- For **children**, until the end of the month in which the **child** turns 26 years of age.
- For all other **dependents**, the day the **dependent** ceases to be eligible.
- The end of the month during which the **group** or **subscriber** provides written notice to us requesting termination of coverage, or on such later date requested for such termination by the notice.
- If the **subscriber** has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by us to the **subscriber**. However, if the **subscriber** makes a misrepresentation of material fact in writing on his or her enrollment application we will rescind coverage if the facts misrepresented would have led us to refuse to issue the coverage. Rescission means that the termination of your coverage will have a retroactive effect of up to your enrollment under the **certificate**. If termination is a result of the **subscriber's** action, coverage will terminate for the **subscriber** and any **dependents**. If termination is a result of the **dependent's** action, coverage will terminate for the **dependent**.
- The date that the **group policy** is terminated. If we terminate and/or decide to stop offering a particular class of **group policies**, without regard to claims experience or health related status, to which this **certificate** belongs, we will provide the **group** and **subscribers** at least 30 days' prior written notice.
- The **group** has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
- The **group** has failed to comply with a material plan provision relating to **group** participation rules. We will provide written notice to the **group** and **subscriber** at least 30 days prior to when the coverage will cease.
- The **group** ceases to meet the statutory requirements to be defined as a **group** for the purposes of obtaining coverage. We will provide written notice to the **group** and **subscriber** at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the *Continuation of coverage* section of this **certificate** for your right to continuation of this coverage under COBRA or USERRA.

SECTION XIII: Extension of benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the **certificate**, an extension of benefits shall be provided for a period of no less than 30 days for completion of a vision procedure that was started before your coverage ended.

To request an extension of coverage**,** just call the toll-free Member Services number on your ID card.

How can you extend coverage for vision care services and supplies when coverage ends?

If your coverage ends while you are not totally disabled**,** your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction.
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**.

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

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of 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.

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until:

- The earlier of one year after the leave of absence begins, or
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury**
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating doctor as **medically necessary** due to a serious **illness** or **injury**

The doctor treating your child will be asked to keep us informed of any changes.

SECTION XIV: Continuation of coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your employer to find out if you are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying events

Pursuant to federal COBRA, you, the **subscriber**, your **spouse** and your **children** may be able to temporarily continue coverage under this **certificate** in certain situations when you would otherwise lose coverage, known as qualifying events.

If your coverage ends due to voluntary or involuntary termination of employment or a change in your employee class (e.g., a reduction in the number of hours of employment) you may continue coverage. Coverage may be continued for you, your **spouse** and any of your covered **children**.

If you are a covered **spouse**, you may continue coverage if your coverage ends due to:

- Voluntary or involuntary termination of the **subscriber's** employment;
- Reduction in the hours worked by the **subscriber** or other change in the **subscriber's** class;
- Divorce or legal separation from the **Subscriber**;
- Death of the **subscriber**; or
- The covered employee becoming entitled to **Medicare**.

If you are a covered **child**, you may continue coverage if your coverage ends due to:

- Voluntary or involuntary termination of the **subscriber's** employment;
- Reduction in the hours worked by the **subscriber** or other change in the **subscriber's** class;
- Loss of covered **child** status under the plan rules;
- Death of the **subscriber**; or
- The covered employee becoming entitled to **Medicare**.

If you want to continue coverage you must request continuation from the **group** in writing and make the first **premium** payment within the 60-day period following the later of:

- The date coverage would otherwise terminate; or
- The date you are sent notice by first class mail of the right of continuation by the **group**.

The **group** may charge up to 102% of the **group premium** for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

- The date 18 months after the **subscriber's** coverage would have terminated because of termination of employment; provided that the **subscriber** or their **dependents** may continue for a total of 29 months if the **member** is determined to be disabled under the United States Social Security Act;
- If You are a covered **spouse** or **child** the date 36 months after coverage would have terminated due to the death of the **subscriber**, divorce or legal separation, the **subscriber's** eligibility for **Medicare**, or the failure to qualify under the definition of "**children**";

- The date you become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
- The date You become entitled to **Medicare**;
- The date to which **premiums** are paid if you fail to make a timely payment; or
- The date the **group policy** terminates. However, if the **group policy** is replaced with similar coverage, you have the right to become covered under the new **group policy** for the balance of the period remaining for your continued coverage.

Continuation rights during active duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and vision care under federal health insurance by reason of their service. Call or write your **group** to find out if you are entitled to temporary continuation of coverage under USERRA.

The **group** may charge up to 102% of the **group premium** for continued coverage. This does not apply if you or your **dependents** serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:

- The 24-month period beginning on the date on which the absence begins; or
- The day after the date on which you or your **dependent** fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

- This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
- If you or your **dependent's** coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their **dependents**, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if you or your **dependents** had become reemployed upon such termination of eligibility.

SECTION XV: General provisions

Administrative provisions

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

We may develop or adopt standards that describe in more detail when we will or will not make payments under this **certificate**. Those standards will not be contrary to the descriptions in this **certificate**. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this **certificate**.

We review and evaluate new technology according to technology evaluation criteria developed by our medical directors and reviewed by a designated committee, which consists of **health care professionals** from various medical specialties. Conclusions of the committee are incorporated into our medical policies to establish decision protocols for determining whether a service is **medically necessary**, **experimental or investigational**, or included as a **covered** benefit.

We are responsible to you for what our employees and other agents do. We are not responsible for what is done by your **vision providers**. They are not our employees or agents.

Agreements between us and participating providers

Any agreement between us and **participating providers** may only be terminated by us or the **providers**. This **certificate** does not require any **provider** to accept a **member** as a patient. We do not guarantee a **member's** admission to any **participating provider** or any vision benefits program.

Assignment

You cannot assign any benefits [or monies due] under this **certificate** to any person, corporation, or other organization. Any assignment of benefits by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this **certificate**. However, you may request us to make payment for services directly to your p**rovider** instead of you.

Changes in this certificate

We may unilaterally change this **certificate** upon renewal, if we give the **group** 30 days' prior written notice.

Choice of law

This **certificate** shall be governed by the laws of the State of New York.

Clerical error

Clerical error, whether by the **group** or us, with respect to this **certificate**, or any other documentation issued by us in connection with this **certificate**, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Conformity with law

Any term of this **certificate** which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

Continuation of benefit limitations

Some of the benefits in this **certificate** may be limited to a specific number of visits, a benefit maximum, and/or subject to a **deductible**. You will not be entitled to any additional benefits if your coverage status should change during the year. For example, if your coverage status changes from covered family **member** to **subscriber**, all benefits previously utilized when you were a covered family **member** will be applied toward your new status as a **subscriber**.

Digital identification cards

Digital identification ("ID") cards are available to you for identification purposes only. Possession of any digital ID card confers no right to services or benefits under this **certificate**. To be entitled to such services or benefits, your **premiums** must be paid in full at the time that the services are sought to be received.

Enrollment ERISA

The **group** will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all **group members** covered under this **certificate**, and any other information required to confirm their eligibility for coverage.

The **group** will provide us with this information upon request. The **group** may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the **group**, or a third party appointed by the **group**. We are not the ERISA plan administrator.

Entire agreement

This **certificate**, including any endorsements, riders and the attached applications, if any, constitutes the entire **certificate**.

Your coverage is defined by the **group policy**. This document may have amendments or riders too. Under certain circumstances, we or your **policyholder** or the law may change your plan. Only we may waive a requirement of your plan. No other person – including your **policyholder** or **vision provider** – can do this.

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or your **policyholder** any unearned **premium**.

Financial sanctions exclusions:

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

Fraud and abusive billing

We have processes to review claims before and after payment to detect fraud and abusive billing. **Members** seeking services from **non-participating providers** could be **balance billed** by the **non-participating provider** for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Furnishing information and audit

The **group** and all **covered persons** under this **certificate** will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this **certificate**. You must provide us with certain information over the telephone for reasons such as the following:

- To determine the level of care you need;
- So that we may certify care authorized by your **provider**; or
- Make decisions regarding the **medical necessity** of your care

The **group** will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to **group** enrollment at the **group's** New York office.

Grace period

A grace period of 31 days after the **premium** due date will be allowed for the payment of each **premium**. If **premiums** are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Honest mistakes

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

Incontestability

No statement made by you will be the basis for avoiding or reducing coverage unless it is in writing and signed by you. All statements contained in any such written instrument shall be deemed representations and not warranties.

Independent contractors

Participating providers are independent contractors. They are not our agents or employees. We and our employees are not the agent or employee of any **participating provider**. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by you, your covered **spouse** or **children** while receiving care from any **participating provider** or in any **participating provider's** facility.

Intentional deception

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

- Loss of coverage, starting at some time in the past.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

Legal action

You are encouraged to complete the appeal process before you take any legal action against us for any expense or bill until you complete the appeal process. You cannot take any action until 60 days after we receive written submission of claim.

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

Material accessibility

We will give the **group**, and the **group** will give you, **certificates**, riders and other necessary materials.

Notice

Any notice that we give you under this **certificate** will be mailed to your address as it appears in our records or delivered electronically if you consent to electronic delivery. You agree to provide us with notice of any change of your address. If you have to give us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Premium contribution

This plan requires the **policyholder** to make **premium** payments. If payments are made through a payroll deduction with the **policyholder**, the **policyholder** will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Premium - missed payments

If you miss a **premium** contribution payment if, for example, you were temporarily absent from work or you have not worked enough hours to cover your payroll deduction, you can make direct payments to us to make your **premium** contributions up to date and keep your coverage active.

To submit a missed **premium** contribution you must follow the missed **premium** contribution payment process set up for this plan. See your employer for details. You must also submit your entire missed **premium** contribution amount for all coverages you have.

We must have your payment within 30 days after the date the **premium** contribution was due. If payment is not received by then, we will not pay for losses or expenses you have during any period of time that **premium** is unpaid.

A missed **premium** contribution payment will not be accepted for any period after your eligibility for coverage ends.

Premium refund

We will give any refund of **premiums**, if due, to the **group**.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians** and **vision providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts.

Recovery of overpayments

We sometimes pay too much for **eligible vision services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **vision provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Right to offset

If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owe us. Except as otherwise required by law, if we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

Severability

The unenforceability or invalidity of any provision of this **certificate** shall not affect the validity and enforceability of the remainder of this **certificate**.

Third party beneficiaries

No third party beneficiaries are intended to be created by this **certificate** and nothing in the **certificate** shall confer upon any person or entity other than you or us any right, benefit, or remedy of any nature whatsoever under or by reason of this **certificate**. No other party can enforce this **certificate's** provisions or seek any remedy arising out of either our or your performance or failure to perform any portion of this **certificate**, or to bring an action or pursuit for the breach of any terms of this **certificate**.

Time to sue

No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this **certificate**. You must start any lawsuit against us under this **certificate** within 2 years from the date the claim was required to be filed.

Translation services

Translation services are available under this **certificate** for non-English speaking **members**. Please contact us at the number on your ID card to access these services.

Waiver

The waiver by any party of any breach of any provision of this **certificate** will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Who may change this certificate

This **certificate** may not be modified, amended, or changed, except in writing and signed by our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this **certificate** in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

Who receives payment under this certificate

Payments under this **certificate** for services provided by a **participating provider** will be made directly by us to the **provider**. If you receive services from a **non-participating provider**, We reserve the right to pay either the **subscriber** or the **provider** regardless of whether an assignment has been made.

Workers' compensation not affected

The coverage provided under this **certificate** is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

Your vision information

We will protect your vision information. We use and share it to help us process your claims and manage your policy. You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on your ID card. When you accept coverage under this policy, you agree to let your **vision providers** share your information with us. We will need information about your physical and mental condition and care.

SECTION XVI: Schedule of benefits

Your schedule of benefits is attached to your **certificate**.

Additional Information Provided by

Outten & Golden, LLP

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Outten & Golden LLP Health and Welfare Plan

Employer Identification Number:
13-4014306

Plan Number:
501

Type of Plan:
Health and Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Outten & Golden, LLP
685 Third Ave 25th Floor
New York, NY 10017
Telephone Number: (917) 282-5176

Agent For Service of Legal Process:
Outten & Golden, LLP
685 Third Ave 25th Floor
New York, NY 10017

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

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Chief Operating Officer.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

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

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

Aetna Life Insurance Company

Amendment

Policyholder: Outten & Golden, LLP

Group Policy number: GP-0149284-D

Amendment effective date: January 1, 2022

Your group policy has changed. The certificate of coverage is revised to reflect this. This change is effective on the date shown above.

1. The *Utilization Review* provision of the certificate has been revised to include the following:

Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

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

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Outten & Golden, LLP
Amendment 1
Issue Date November 10, 2021

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

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

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

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

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

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

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

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

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

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

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

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

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