

# BENEFIT PLAN

Prepared Exclusively for  
President and Trustees of Bates College

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 Booklet-Certificate describes only the benefits insured by Aetna. Please refer to the plan design summary provided by your employer for a description of any discount arrangements that may apply.**

**aetna**<sup>SM</sup>

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\*Defines the Terms Shown in Bold Type in the Text of This Document.

## Preface (GR-9N-02-005-01 ME)

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	President and Trustees of Bates College
Group Policy Number:	GP-869807
Effective Date:	January 1, 2016
Issue Date:	April 7, 2016
Booklet-Certificate Number:	4



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

## **Important Information Regarding Availability of Coverage** (GR-9N-02-020-01 ME)

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an accident, **injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, “*Termination of Coverage (Extension of Benefits)*” and “*Continuation of Coverage*” for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

## **Coverage for You and Your Dependents** (GR-9N-02-020-01 ME)

### **Health Expense Coverage** (GR-9N-02-020-01 ME)

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

### **Treatment Outcomes of Covered Services** (GR-9N-02-020-01 ME)

**Aetna** is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

# When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

## Who Can Be Covered

### Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class”, as defined below; and
- You will need to meet the “eligibility date criteria” described below.

### Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

### Probationary Period (GR-9N-29-005-02)

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

### Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

#### On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

#### After the Effective Date of the Plan

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 1 month of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

### Obtaining Coverage for Dependents (GR-9N-29-010-01 ME)

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by the state of Maine; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

## Coverage for Domestic Partner (GR-9N-29-010-01 ME)

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is a mentally competent adult;
- He or she is engaged with you in a close, committed and monogamous personal relationship;
- He or she has been sharing the same household with you on a continuous basis for at least 12 months;
- He or she is not married to, or separated from, another individual;
- He or she demonstrates evidence of domestic partnership by submission of an affidavit of partnership, if requested, which shows documentation of:
  - Common ownership of real property or a common leasehold interest in such property;
  - Common ownership of joint personal property;
  - Joint bank accounts or credit accounts; or
  - Assignment of a durable power of attorney or health care power of attorney.

You may not enroll another individual as a domestic partner under until 12 months after the termination of coverage for a prior domestic partner.

## Coverage for Dependent Children (GR-9N-29-010-06)

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

### Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

## How and When to Enroll (GR-9N 29-015 02-ME)

### Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

## **Annual Enrollment**

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period.

## **When Your Coverage Begins** (GR-9N 29-025 02-ME)

### **Your Effective Date of Coverage**

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date your enrollment form is received; and
- The date your required contribution is received by **Aetna**.

#### **Important Notice:**

You must pay the required contribution in full.

### **Your Dependent's Effective Date of Coverage**

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

**Note:** New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions.

# Requirements For Coverage (GR-9N-09-005 01 ME)

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
  - Be included as a covered expense in this Booklet-Certificate;
  - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
  - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
  - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.
2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The health care must be medically necessary. “Medically necessary health care” means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:
  - (a) Consistent with generally accepted standards of medical practice;
  - (b) Clinically appropriate in terms of type, frequency, extent, site and duration;
  - (c) Demonstrated through scientific evidence to be effective in improving health outcomes;
  - (d) Representative of “best practices” in the medical profession; and
  - (e) Not primarily for the convenience of the enrollee or physician or other health care practitioner.

## Important Note

Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

## Your Aetna Vision Expense Plan (GR-9N-22-005-02 ME)

It is important that you have the information and useful resources to help you get the most out of your **Aetna** vision expense plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access services, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility; complaints and appeals; termination; continuation of coverage; and general administration of the plan.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the: terms; policies; and procedures outlined in this Booklet-Certificate. Not all vision care expenses are covered under the plan. Exclusions and limitations apply to certain: services; supplies; and expenses. Refer to the *What the Plan Covers; Exclusions; and Schedule of Benefits* sections to determine what expenses are covered; excluded or limited.

**Important Notes:**

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your vision plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are medically necessary.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive vision care services that are not or might not be covered benefits under this vision expense plan.
- Store this Booklet-Certificate in a safe place for future reference.

## Getting Started: Common Terms (GR-9N 22-010 01)

You will find terms used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

## About the Aetna Vision Preferred Expense Plan (GR-9N-22-020-02 ME)

This **Aetna** comprehensive vision care insurance plan is designed to cover a wide range of vision services and supplies. Benefits are payable for each covered person as shown in the *Schedule of Benefits* for expenses incurred while this insurance is in force.

This plan provides access to covered benefits through a network of vision care **providers**. These network **physicians** and other vision care professionals have contracted with **Aetna** or an affiliate to provide vision care services and supplies to **Aetna** plan members at a fee called the **negotiated charge**.

Your **copayments** and **coinsurance** will usually be lower when you use participating **network providers** and facilities.

You also have the choice to access licensed **providers** outside the **network** for covered benefits. **Coinsurance** is usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan.

To better understand the choices that you have with your plan, please carefully review the following information. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

### Availability of Providers

**Aetna** cannot guarantee the availability or continued network participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract.

### Ongoing Reviews

**Aetna** conducts ongoing reviews of those services and supplies which are recommended or provided by vision professionals to determine whether such services and supplies are covered benefits under this Booklet-Certificate. If **Aetna** determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Claim Procedures/Complaints and Appeals* section of this Booklet-Certificate.

# How Your Plan Works

## Accessing Network Providers and Benefits

- You may select a **network** vision care **provider** from the **Aetna Network Provider Directory** or by logging on to **Aetna's** website at [www.aetna.com](http://www.aetna.com). You can search **Aetna's** online **directory**, DocFind, for names and locations of **physicians** and other vision care **providers** and facilities. You can change your vision care **provider** at any time.
- If a service you need is covered under the plan but not available from a **network provider**, please contact Member Services at the toll-free number on your ID card for assistance.
- You will not have to submit claims for services and supplies received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **coinsurance** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **copayment**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

## Cost Sharing For Network Benefits

### Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- For certain types of services and supplies, you will be responsible for any **copayment** shown in the *Schedule of Benefits*.
- Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **copayment** or **coinsurance** amounts, or any non-covered expenses that you incur.

## Accessing Out-of-Network Providers and Benefits (GR-9N-22-025-02 ME)

You have the choice to directly access **physicians** or other vision care **providers** that do not participate with the **Aetna** provider network. You will still have coverage when you access **out-of-network providers** for covered benefits. You may have more out-of-pocket expenses.

- You select a **provider** for covered benefits.
- You may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the **provider**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.
- If your **provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from a **provider**.

You will receive notification of what the plan has paid toward your medical expenses. It will indicate any amounts you owe towards your **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

## Cost Sharing for Out-of-Network Benefits

### Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- Your **coinsurance** will be based on the **recognized charge**. If the health care **provider** you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefit* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.

## Comprehensive Vision Expense Plan (GR-9N-24-005-02 ME)

### What the Plan Covers

This plan covers charges for certain vision care exams and supplies described in this section. The plan limits coverage to a maximum benefit amount per Benefit Period. Refer to your *Schedule of Benefits* to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum, listed in the *Schedule of Benefits*.

### Vision Exams

**Covered expenses** include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- Routine eye exam: A complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.

Benefits are payable up to the benefit maximum listed on your *Schedule of Benefits*. Refer to the *Schedule of Benefits* for frequency limits and maximums on exams.

### Vision Supplies

**Covered expenses** include charges for prescription lenses and frames, or prescription contact lenses up to the benefit maximum, per benefit period listed in the *Schedule of Benefits*.

### Prescription Lenses

**Covered expenses** include **prescription** lenses prescribed for the first time and new lenses required due to a change in **prescription** up to the benefit maximum, listed in your *Schedule of Benefits*.

- Charges for **prescription** contact lenses will be covered.

Benefits are payable up to the benefit maximum, per benefit period, listed in the *Schedule of Benefits*.

**Covered expenses** also include

- Aphakic lenses prescribed after cataract surgery; and
- Contact lenses required to correct visual acuity to 20/40 or better in the better eye if such correction cannot be made with conventional lenses.

Benefits for these lenses are payable up to the benefit maximums, per benefit period, listed on the *Schedule of Benefits*. You are responsible for any cost-sharing amounts listed in the *Schedule of Benefits*.

## Frames

**Covered expenses** include expenses for frames if the lenses for them are covered under this section.

Eyeglass frames are covered when purchased with **prescription** lenses up to the benefit maximum, per benefit period, listed in your *Schedule of Benefits*.

## Limitations

All **covered expenses** are subject to the vision expense exclusions in this Booklet-Certificate and are subject to the **copayments** or **coinsurance** listed in the *Schedule of Benefits*, if any.

Coverage is subject to the exclusions listed in the *Vision Plan Exclusions* section of this Booklet-Certificate.

## Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

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

Coverage is subject to the benefit maximums described above and in your *Schedule of Benefits*.

## Vision Plan Exclusions (GR-9N-28-030-02-ME)

Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician**. The plan covers only those services and supplies that are included in the *What the Plan Covers* section.

Charges made for the following are **not** covered. In addition, some services are specifically limited or excluded. This section describes expenses that are **not** covered or subject to special limitations.

Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet-Certificate.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital, physician** or other provider or not within the scope of the provider's license.

Any exams given during your **stay** in a **hospital** or other facility for medical care.

An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.

Drugs or medicines.

**Experimental** or **investigational** drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.

For an eye exam which:

- Is required by an employer as a condition of employment; or
- An employer is required to provide under a labor agreement; or
- Is required by any law of a government.

Eye exams to diagnose or treat an illness or **injury**.

Acuity tests.

**Prescription** or over-the-counter drugs or medicines.

Special vision procedures, such as orthoptics, vision therapy or vision training.

Vision service or supply which does not meet professionally accepted standards.

Anti-reflective coatings.

Tinting of eyeglass lenses.

Duplicate or spare eyeglasses or lenses or frames for them.

Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.

Replacement of lost, stolen or broken **prescription** lenses or frames.

Special supplies such as nonprescription sunglasses and subnormal vision aids.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Services to treat errors of refraction.

Vision services that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder; or
- Under any workers' compensation law or any other law of like purpose.

# When Coverage Ends (GR-9N-30-015-04)

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

## When Coverage Ends for Employees (GR-9N-30-005-05 ME)

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for the purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not at work due to disease or **injury**, your employment may be continued until stopped by your employer, but not beyond 30 months from the start of the absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

## When Coverage Ends for Dependents (GR-9N-30-015-02)

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends for Employees*. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

# Continuation of Coverage (GR-9N 31-015-05 ME)

## Continuing Health Care Benefits (GR-9N-31-015-06)

### Continuing Coverage

If you:

- terminate employment due to a temporary lay-off; or
- lose employment due to an **injury** or disease that you claim to be compensable under workers' compensation;

You may continue any Health Expense Coverage (except Comprehensive Dental Expense Coverage) then in force if:

- you have been employed by your employer for at least 6 months;
- you are not eligible for Medicare;
- you are not covered for like benefits;
- you are not eligible for like benefits under any group plan;
- you are not eligible for continuation of like benefits because of any state or federal law; and
- premium payments are continued.

The coverage may be continued for you or any of your dependents who have been covered as your dependent for at least 3 months or for you and any such dependents. If a dependent has not been eligible for 3 months, the dependent must have been covered at all times while eligible.

You have to make request in writing for this continuation. This must be done within 31 days of the date coverage would otherwise cease. The request must include an agreement to pay up to 102% of the applicable group rate.

Coverage will cease on the first to occur of:

- The date you are eligible for coverage under any other group plan.
- The date you fail to make the contributions needed.
- The date the Workers' Compensation Commission determines that the disease or **injury**, that entitled the person to continued coverage, is not compensable.
- The end of a one year period which starts on the date coverage would otherwise cease.

Coverage of a dependent will cease earlier when the dependent ceases to be a defined dependent.

If any coverage being continued ceases because it has been continued for one year, the person may apply for a personal policy in accordance with the Conversion Privilege. If it ceases for any other reason, the Conversion Privilege is not available.

## Continuing Coverage for Dependent Students on Medical Leave of Absence (GR-9N 31-015 01 ME)

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness or injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

#### **Important Note**

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

### **Handicapped Dependent Children** (GR-9N 31-015 01 ME)

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

**Aetna** will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

# COBRA Continuation of Coverage

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

## Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

## Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

<b>Qualifying Event Causing Loss of Health Coverage</b>	<b>Covered Persons Eligible to Elect Continuation</b>	<b>Maximum Continuation Periods</b>
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

## **Disability May Increase Maximum Continuation to 29 Months**

*If You or Your Covered Dependents Are Disabled.*

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18<sup>th</sup> month, through the 29<sup>th</sup> month.

*If There Are Multiple Qualifying Events.*

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

## **Determining Your Premium Payments for Continuation Coverage**

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

## **When You Acquire a Dependent During a Continuation Period**

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

### **Important Note**

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

## **When Your COBRA Continuation Coverage Ends**

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is neither disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.

- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

# General Provisions (GR-9N-32-005-02-ME)

## Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

## Physical Examinations

**Aetna** will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

## Legal Action

The following information does not apply to Life Insurance.

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

## Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** Notice of Information Practices by calling **Aetna's** toll-free Member Service telephone.

## Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

## Assignments (GR-9N 32-005-01 ME)

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this group insurance policy.

## Misstatements (GR-9N-32-005-03)

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

**Aetna's** failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

## Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

## Recovery of Overpayments (GR-9N-32-015-01 ME)

### Health Coverage

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

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

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

## Reporting of Claims (GR-9N-32-020-01 ME) (GR-9N-32-015-01 ME)

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

## Payment of Benefits (GR-9N-32-025-02)

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

**Aetna** will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

**Aetna** may pay up to \$1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

## Records of Expenses (GR-9N-32-030-02)

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

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

## Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

You may also use **Aetna's** toll free Member Services phone number on your ID card or visit **Aetna's** web site at [www.aetna.com](http://www.aetna.com).

## Discount Programs (GR-9N 32-045-01)

### Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

### Incentives (GR-9N 32-045-01)

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, coinsurance, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

# Glossary

(GR-9N 34-005 01)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

## A (GR-9N-34-005-05 ME)

### **Aetna**

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

## C (GR-9N 34-015 02)

### **Coinsurance**

**Coinsurance** is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as “plan **coinsurance**” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

### **Copay or Copayment**

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

### **Covered Expenses**

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

## D (GR-9N 34-020 01)

### **Deductible**

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

### **Directory**

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

## H (GR-9N 34-040 02)

### **Hospital**

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;

- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

**In no event** does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

## I (GR-9N 34-045 02)

### Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

### Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

## M (GR-9N-34-065-03 ME)

### Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

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

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

## **N** (GR-9N 34-070 02)

### **Negotiated Charge**

The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

### **Network Provider**

A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

### **Non-Occupational Illness**

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

### **Non-Occupational Injury**

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

## **O** (GR-9N-34-075-01 ME)

### **Occupational Injury or Occupational Illness**

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

### **Occurrence**

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

### **Out-of-Network Provider**

A health care provider who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

## **P** *(GR-9N-34-080-05 ME)*

### **Physician**

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

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

Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician. These include, but may not be limited to the following:

- Acupuncturist;
- Chiropractor;
- Optometrist;
- Certified Registered Nurse Anesthetists;
- Certified Nurse Midwives;
- Certified Nurse practitioner;
- Registered Nurse First Assistant.

### **Premium Progressive Lenses**

These are multi-focal lenses that produce a gradual change in focus without lines or junctions and are the manufacturer's highest technology lenses.

### **Prescriber**

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

### **Prescription**

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

### **Prescription Drug**

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

## **Recognized Charge** (GR-9N-34-090-02 ME)

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to vision expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the Prevailing Charge Rate;
  - for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

**Aetna** may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

**Aetna** Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community or which is otherwise consistent with **physician** recommendations; and the views of **physicians** practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are rates reported in the Prevailing Health Care Charges System (PHCS) database.

### **Important Note**

**Aetna** periodically updates its systems with changes made to the Prevailing Charge Rates.

*What this means to you* is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

### **Additional Information**

**Aetna's** website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

**S** *(GR-9N 34-095-05)*

### **Standard Progressive Lenses**

These are multi-focal lenses that produce a gradual change in focus without lines or junctions but are not the manufacturer's highest technology lenses.

### **Stay**

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

## **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](http://www.aetna.com).

# **Additional Information Provided by President and Trustees of Bates College**

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:**

President and Trustees of Bates College

**Employer Identification Number:**

01-0211781

**Plan Number:**

528

**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:**

President and Trustees of Bates College  
215 College Street  
Lewiston, ME 04240  
Telephone Number: (207) 786-8271

**Agent For Service of Legal Process:**

President and Trustees of Bates College  
215 College Street  
Lewiston, ME 04240

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

**End of Plan Year:**

December 31

**Source of Contributions:**

Employer and Employee

**Procedure for Amending the Plan:**

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

## **ERISA Rights**

As a participant in the group 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

### **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.

## **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 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 FMLA 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.

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## **Amendment** *(GR-9N-Appeals 01-01 01-ME)*

**Policyholder:** President and Trustees of Bates College  
**Group Policy No.:** GP-869807  
**Rider:** Maine Complaint & Appeals Health Rider  
**Issue Date:** April 7, 2016  
**Effective Date:** January 1, 2016

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

## **Appeals Procedure**

### **Definitions**

**Aetna:** Aetna Life Insurance Company

**Adverse Benefit Determination:** A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

**Appeal:** An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

**Complaint:** Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a previously approved course of treatment.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a previously approved course of treatment.

**Pre-service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim:** Any claim that is not a "Pre-Service Claim."

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:

- place in jeopardy your life;
- place in jeopardy your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

## **Claim Determinations** *(GR-9N-Appeals 01-02 01-ME)*

### **Urgent Care Claims**

**Aetna** will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

### **Pre-Service Claims**

**Aetna** will make notification of a claim determination for non-urgent services as soon as possible but not later than 2 business days after obtaining all necessary information. **Aetna** will not later render an adverse decision with respect to any pre-authorized services except if fraudulent or materially incorrect information was provided at the time the services were pre-authorized, and such information was used in pre-authorizing the services.

### **Post-service Claims**

**Aetna** will make notification of a claim determination within 14 business days for claims involving utilization review. Other wise, as soon as possible but not later than 30 calendar days after the post-service claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information. In the case of an **adverse benefit determination**, **Aetna** will notify you in writing within 5 days after making the determination.

### **Concurrent Care Claim Extension**

Following a request for a **concurrent care claim extension**, **Aetna** will make notification of a claim determination within one business day of obtaining all necessary information.

### **Concurrent Care Claim Reduction or Termination**

**Aetna** will make notification of a claim determination to reduce or terminate a previously approved course of treatment within one business day of obtaining all necessary information.

## **Complaints** *(GR-9N-Appeals 01-05 01-ME)*

If you are dissatisfied with the administrative services you receive from the plan or want to complain about a **provider** you must call or write **Aetna** Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

## **Appeals of Adverse Benefit Determinations** *(GR-9N-Appeals 01-06 01-ME)*

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted orally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of **Aetna's** notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to Aetna.

### **Level One Appeal - Group Health Claims** *(GR-2N-Appeals 01-07 01-ME)*

#### **For Utilization Review**

A level one **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**. Except for Urgent Care Claims, an acknowledgement letter will be sent to you within three (3) business days of **Aetna's** receipt of the **appeal**. The letter will contain the name; address; and telephone number of the Appeal Coordinator assigned to review the appeal. If the appeal concerns medical necessity; appropriateness; health care setting; level of care; or effectiveness the Coordinator will be a clinical peer health care professional. If the letter requests additional information, it must be sent to **Aetna** within the next 15 days.

#### **Urgent care claims** (May Include **concurrent care claim reduction or termination**)

**Aetna** shall issue a decision within 36 hours of receipt of the request for an **appeal**.

#### **Pre-service claims** (May Include **concurrent care claim reduction or termination**)

**Aetna** shall issue a decision within 15 calendar days of receipt of the request for an **appeal** or receipt of any additional information requested.

#### **Post-Service Claims**

**Aetna** shall issue a decision within 20 calendar days of receipt of the request for an **appeal** or receipt of any additional information requested.

If **Aetna's** final decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the review;
- A statement of the Coordinator's understanding of the **appeal**; and all pertinent facts;
- The Coordinator's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials;
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau;
- A description of the process to obtain a level two **appeal** (including the rights; procedures; and time frames that govern such an **appeal**).

**For Other Than Utilization Review** A level one **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**.

#### **Urgent care claims** (May Include **concurrent care claim reduction or termination**)

**Aetna** shall issue a decision within 24 hours of receipt of the request for an **appeal**.

#### **Pre-service claims** (May Include **concurrent care claim reduction or termination**)

**Aetna** shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

### **Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

### **Level Two Appeal (Applies Only to Group Health Claims)**

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of a decision involving an **Urgent Care Claim**, or a claim involving medical necessity; appropriateness; health care setting; level of care; or effectiveness; shall be provided by the **Aetna Appeals Committee**. The majority of the Committee will be made up of persons not previously involved in the **appeal**. However, a person who was previously involved in the **appeal** may be a member of the Committee. Such person may also appear before the Committee to present information or answer questions. The Committee must include at least one clinical peer health care professional who was not previously involved in the **appeal**.

For a level two **appeal** concerning all other appeals, the majority of the Committee will be made up of employees or representatives of **Aetna** who were not previously involved with the **appeal**. However, a person who was previously involved in the **appeal** may be a member of the Committee. The person may also appear before the Committee to present information; or answer questions.

If you are asked to appear in person before the Committee, the Committee will notify you in writing in advance of the hearing date. The notice will also advise you if an attorney will be present to argue **Aetna's** case against you. **Aetna** will also advise you of your right to obtain legal representation. The hearing will be held during regular business hours. If you can not attend the hearing, you may participate by conference call; or other available technology; at **Aetna's** expense. You may also request that **Aetna** consider a postponement and rescheduling of the hearing. In addition:

- You may request **Aetna** to provide you with all relevant information that is not confidential or privileged.
- You may be helped or represented at the hearing by the person of your choice.
- You may submit supporting material. This may be done both before and during the hearing.
- You may ask questions of any **Aetna** representative.

### **Urgent Care Claims (May Include concurrent care claim reduction or termination)**

Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal**.

### **Pre-Service Claims (May Include concurrent care claim reduction or termination)**

Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

### **Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

If the decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the level one **appeal** review;
- A statement of the Committee's understanding of the **appeal** and all pertinent facts;
- The Committee's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials; and
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau.

**Aetna** will keep the records of your **complaint** for 3 years.

## NOTICE:

You may contact the Maine Bureau of Insurance at any time during the **appeal** process outlined above. The address is:

Maine Bureau of Insurance  
Consumer Health Care Division  
34 State House Station  
Augusta, Maine 04333  
Telephone Number: 1-800-300-5000  
Web: [www.state.me.us/pfr/ins/ins\\_index.htm](http://www.state.me.us/pfr/ins/ins_index.htm)

## Exhaustion of Process *(GR-9N-Appeals 01-10 01-ME)*

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you can establish any:

- litigation;
- arbitration; or
- administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

## External Review *(GR-9N-Appeals 01-11 01-ME)*

If **Aetna** renders a decision resulting in an **adverse benefit determination** you may contact the Maine Bureau of Insurance to request an external review; if you or your provider disagrees with **Aetna's** decision. An external review is a review by an independent external review organization, who has expertise in the problem or question involved. The Maine Bureau of Insurance oversees the external review process. It also contracts with approved independent review organizations to carry out the external review and render a decision.

To request an external review, the following requirements must be met:

- You have received notice of an **adverse benefit determination** from **Aetna**; and
- You have exhausted the applicable internal **appeal** processes.

The **adverse benefit determination** you receive from **Aetna** will describe:

- the external review process and the procedure to follow if you wish to pursue an external review;
- your right to get assistance from **Aetna** to request the external review;
- your right to attend the external review; submit; and obtain supporting material relating to the adverse decision; ask questions of any **Aetna** representative; and have outside assistance; and
- your right to seek assistance from; or file a complaint with; the Maine Bureau of Insurance (including the Bureau's address and toll-free number).

You or your authorized representative must send the request for external review in writing to the Maine Bureau of Insurance. The request must be made within 12 months of the date you received the final adverse decision letter from **Aetna**. You also must include: a copy of the final adverse decision letter; and all other pertinent information that supports your request. You will not be required to pay any fees.

Expedited request for external review: You will not be required to exhaust the applicable internal **appeals** process before requesting an external review if:

- **Aetna** has failed to make a decision within the required time period; or
- You and **Aetna** agree to bypass the internal **appeals** procedure; or

- Your life or health is in serious jeopardy; or
- You have died.

The Maine Bureau of Insurance will contact the external review organization that will conduct the review of your claim. The external review organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external review organization will consider how appropriate the service is based on:

- All relevant clinical information relating to your physical and mental condition;
- Any concerns you have voiced about your health status; and
- All relevant clinical standards, including but not limited to, those standards and guidelines used by **Aetna**.

You will be notified of the decision of the external review organization within 30 calendar days of receipt of your request form and all necessary information from the Maine Bureau of Insurance. If your condition is such that a delay would put in serious jeopardy your life or health or your ability to regain maximum function, a decision will be made no later than 72 hours after receipt of the request.

**Aetna** will abide by the decision of the external review organization.

**Aetna** is responsible for paying the Maine Bureau of Insurance for the cost of the external review.

For more information about the external review process, call the toll-free Customer Services telephone number shown on your ID card.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# BENEFIT PLAN

## Extraterritorial Riders

Prepared Exclusively for  
President and Trustees of Bates College

Aetna Vision Preferred Extraterritorial Riders

Aetna Life Insurance Company

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

**aetna**<sup>SM</sup>

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# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Extraterritorial Certificate Rider *(GR-9N-CR1)*

**Policyholder:** President and Trustees of Bates College  
**Group Policy No.:** GP-869807  
**Rider:** Massachusetts ET Vision  
**Issue Date:** April 7, 2016  
**Effective Date:** January 1, 2016

This certificate rider forms a part of the Booklet-Certificate issued to you by **Aetna** describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other vision extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable **ONLY** for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. **These benefits supersede any provision in your Booklet-Certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the Group Policy and Booklet-Certificate.

### Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

### Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French

### Services d'interprétation et de traduction

Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

### **Υπηρεσίες Μεταφρασεως**

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χωρις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αetna το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιοουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

### **Servizi di traduzione e di interpretariato**

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizi di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

### **Serviços de Intérprete e de Tradução**

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dificuldades com a audição.

Russian

### **Услуги по устному и письменному переводу**

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугам по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

### **Servicio de Intérprete y Traducción**

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la línea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

### **Sèvis intèprèt ak tradiktè**

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

**ານບໍລິການນາຍພາສາຜະການຜູ້ພາສາ**

ານສາມາດຕິດຕໍ່ຜະການບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຜູ້ທີ່ປາກົດເທິງບັດປະຈຳ ວິສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາຜະ ລິການຜູ້ພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ຜະການບໍລິການລູກຄ້າຂອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານຜູ້ພາສາໄດ້ ໂດຍຜ່ານສາຍຜູ້ພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິງສຽງບໍ່ຄັກໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

**ເສຳກຳຜູ້ຜູ້ກຳປູເຈຍ**

**ຜູ້ກຳກັບອາກິດສະເສຳກຳຜູ້ສາມາດ ຄາຍຮຽນເລຂ ຄັດຄິດໄຊ ໃຊ້ໃນຜູ້ເຮົາເຮົາສຳຄັນສຳລັບຮູບ**

**ຜູ້ ເຊີຍຊື່ອຸດຕິຍາດ ທີ່ ເສຳກຳຜູ້ຜູ້ກຳປູເຈຍ ໃຊ້ໃນອາກິດສະເສຳກຳຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ**

**ຜູ້ກຳກັບອາກິດສະເສຳກຳຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ**

**ຄາຍຮຽນເລຂ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ ທີ່ ຜູ້ສາມາດ**

Chinese

**口譯及筆譯服務**

您可以通过拨打列在您会员卡上的免费电话号码与会员服务处联系，以便获取有关实施程序的口译及笔译服务的资讯。Aetna的專業用戶服務人員使用AT&T語言專線 (AT&T Language Line) 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的TDD號碼。

Arabic

**خدمات الترجمة الشفهية والكتابية**

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتنا للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأسماء أيضاً رقم جهاز إتصالات الأسماء (TDD).

(GR-9N 29-010-01)

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

### **When You Receive a Qualified Child Support Order** *(GR-9N 29-015-01 MA)*

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, **Aetna** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.

### **Thirty-One Day Continuation** *(GR-9N 31-015-01 MA)*

Coverage under this plan, which terminates in accordance with the prior terms of this section, will be continued for 31 more days, subject to the following:

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to **Aetna** within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

### **Continuation of Coverage for Your Former Spouse**

If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.

- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

### **Continuation of Coverage: Employment Ceases**

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.
- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

### **Continuation of Coverage: Plant Closing**

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

### **Continuation of Coverage for Your Dependents After Your Death**

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent's coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Extraterritorial Certificate Rider (GR-9N-CR1)

**Policyholder:** President and Trustees of Bates College  
**Group Policy No.:** GP-869807  
**Rider:** New Jersey ET Vision  
**Issue Date:** April 7, 2016  
**Effective Date:** January 1, 2016

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other vision extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of New Jersey. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of New Jersey, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

## Obtaining Coverage for Dependents (GR-9N 29-010 03 NJ)

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/**civil union partner**; or
- Your domestic partner who meets the rules as defined by the State of New Jersey; and
- Your dependent children; and
- Dependent children of your domestic partner.

**Aetna** will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

## Civil Union Partner (GR-9N 34-015 02 NJ)

A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to “marriage”, “husband”, “wife”, “family”, “immediate family”, “dependent”, “next of kin”, “widow”, “widower”, “widowed” or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Extraterritorial Certificate Rider (GR-9N-CR1)

**Policyholder:** President and Trustees of Bates College  
**Group Policy No.:** GP-869807  
**Rider:** New York ET Vision  
**Issue Date:** April 7, 2016  
**Effective Date:** January 1, 2016

This certificate rider forms a part of the Booklet-Certificate issued to you by **Aetna** describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other vision extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable **ONLY** for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of New York. **These benefits supersede any provision in your Booklet-Certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of New York, and if the benefit value exceeds those benefits covered under the Group Policy and Booklet-Certificate.

## Payment of Benefits (GR-9N-32-025-01 NY)

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than 45 days after receipt of such proof. Written proof must be provided for all benefits.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Extraterritorial Certificate Rider *(GR-2N-CR1)*

**Policyholder:** President and Trustees of Bates College  
**Group Policy No.:** GP-869807  
**Rider:** Rhode Island ET Vision  
**Issue Date:** April 7, 2016  
**Effective Date:** January 1, 2016

This certificate rider forms a part of the Booklet-Certificate issued to you by **Aetna** describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other vision extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable **ONLY** for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and/or your dependents;
- The benefits in this rider are specific to residents of Rhode Island. **These benefits supersede any provision in your Booklet-Certificate to the contrary unless the provisions in your certificate result in greater benefits.** You are only entitled to these benefits, if you are a resident of Rhode Island, and if the benefit value exceeds those benefits covered under the Group Policy and Booklet-Certificate.

## Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
  - Under age 26, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support\*; or
  - An unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than (12) twelve months. Aetna will have the right to require proof of the medically determined physical or mental impairment and examine the unmarried child, at its own expense, as often as needed while the medically determined physical or mental impairment continues. Coverage will cease on the first to occur of the date the child marries; cessation of the medically determined physical or mental impairment; failure to give proof that the medically determined physical or mental impairment continues; failure to have any required exam.

**\*Note:** Proof of a student's full or part-time enrollment in a post-secondary institution is required each year.

# Appeals Procedure<sup>(GR-9N 32-050 01)</sup>

## Definitions

**Adverse Benefit Determination (Decision):** A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

**Appeal:** A written request to **Aetna** to reconsider an **adverse benefit determination**.

**Complaint:** Any written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a course of treatment that was previously approved.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a course of treatment that was previously approved.

**External Review:** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner and made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

**Final Adverse Benefit Determination:** An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

**Pre-service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

## Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and appeals only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

## Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a **concurrent care claim**, to your **provider**.

## Urgent Care Claims

**Aetna** will notify you of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide **Aetna** with the information.

## Pre-Service Claims

**Aetna** will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

## Post-Service Claims

**Aetna** will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

## Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

## Concurrent Care Claim Reduction or Termination

**Aetna** will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

## Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

## Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal** depending upon the type of coverage provided under the Plan. A **final adverse benefit determination** notice will also provide an option to request an **External Review** (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- The employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

### Level One Appeal

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

### Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

**Aetna** shall issue a decision within 36 hours of receipt of the request for an **appeal**.

### Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

**Aetna** shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

### Post-Service Claims

**Aetna** shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

### Level Two Appeal

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

### **Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)**

**Aetna** shall issue a decision within 36 hours of receipt of the request for a Level Two **Appeal**.

### **Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)**

**Aetna** shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

### **Post-Service Claims**

**Aetna** shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.

## **Exhaustion of Process**

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Rhode Island Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a **complaint** or **appeal** with the Rhode Island Department of Insurance; or
- Establish any:
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Under certain circumstances, you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

### **Important Note:**

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**.

Your claim or internal **appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

## **External Review**(GR-2N 32-051 01)

You may receive an **adverse benefit determination** or **final adverse benefit determination**.

In these situations, you may request an **External Review** if you or your **provider** disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna**, and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.
- You qualify for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds \$500.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the U.S. Office of Personnel Management within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

**Aetna** will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Amendment

<b>Policyholder:</b>	President and Trustees of Bates College
<b>Group Policy No.:</b>	GP-869807
<b>Rider:</b>	Texas ET Vision
<b>Issue Date:</b>	April 7, 2016
<b>Effective Date:</b>	January 1, 2016
<b>Texas:</b>	Vision Expense Coverage

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other vision extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents.

The benefits in this rider are specific to residents of Texas. If the benefits for covered expenses in this rider have no corresponding covered expense in the booklet certificate, then the covered expenses in this rider are in addition to the benefits provided under your booklet certificate. The benefits for covered expenses in this rider replace any benefits for covered expenses for the same benefit in the booklet certificate.

Except as otherwise shown in this rider, the benefits in this rider are subject to the annual limits and overall coverage year maximum (if any) specified in your booklet certificate.

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call Aetna's toll-free telephone number for information or to make a complaint at

1-800-MY-Health (694-3258)

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX No. (512) 475-1771

**Premium or Claim Disputes:**

Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

**Notice:**

This notice is for information only and does not become a part or condition of your Policy.

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al

1-800-MY-Health (694-3258)

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX No. (512) 475-1771

**Disputas Sobre Primas o Reclamaciones:**

Si surge una disputa su concierne a prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

**Aviso:**

Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Póliza.

## Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: [www.aetna.com](http://www.aetna.com) or by calling 1-800-MY-Health (694-3258) for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than \$1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website:

**[www.tdi.texas.gov/consumer/cpmmediation.html](http://www.tdi.texas.gov/consumer/cpmmediation.html).**  
**Texas Department of Insurance Notice**

## Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried and under age 25.

To be eligible, a dependent grandchild must be:

- The unmarried child of your child; and
- Under age 25; and
- Supported by you for Federal Income Tax purposes on the date of his or her initial application for coverage. Coverage will not terminate solely due to the child's loss of such Federal Income Tax dependency status; or
- Any age, if medically certified as disabled and dependent on the parent.

Your children can include the following:

- Your biological children;
- Your stepchildren;
- Your legally adopted children; including any child placed with you for adoption and any child for whom you are a party in a suit in which the adoption of the child is sought;
- Your foster children;
- Any child for whom you or your covered spouse is under court order for medical support. This child is covered immediately upon **Aetna's** notification of such order;
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

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

## Continuing Coverage for Dependents After Your Death

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

- You were covered at the time of your death;
- Your coverage, at the time of your death, is not being continued after your employment has ended;
- A request is made for continued coverage within 60 days after your death; and
- Payment is made for the coverage.

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

- The end of the 3 year period following your death;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop.

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

### Important Note

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

## **Continuation of Coverage for Your Dependents After Your Retirement**

If coverage for your dependents would terminate because you retire while covered under any part of this plan, any coverage then in force for your dependents may be continued. Continuation must be requested within 60 days after your retirement. Premium payments for the coverage must be continued.

Your dependent's coverage will not continue beyond the first to occur of:

- The end of a 3 year period starting on the date of your retirement.
- The date a dependent becomes eligible for coverage under any group plan providing health benefits.
- The date dependent coverage under this Plan is discontinued.
- The end of the period for which any required contributions have been made.

If any coverage being continued terminates, the person may apply for a personal policy in accordance with the conversion privilege.

## **Continuing Health Care Benefits**

You may continue coverage under the plan which terminates for you and your dependents, for any reason, except involuntary termination of employment due to cause, but only if you have been covered under this plan for at least 3 months in a row prior to such termination.

You must request the continuation in writing within 31 days of the later to occur of:

- the date coverage would otherwise cease; and
- the date your employer or group policy holder provides you with the notice of your right to continue coverage.

Premium payments must be continued. The required contribution for continued coverage may not exceed 102% of the group rate.

Continuation for a person may not terminate until the earliest of:

- 6 months after the date the election is made.
- The end of the period for which required contributions are made.
- The date the person is or could be covered by Medicare.
- The date the person is covered or is eligible for similar benefits under another medical expense plan.
- The date the person has similar benefits available pursuant to any state or federal law.

Coverage for a dependent will cease earlier when the person:

- ceases to be a defined dependent under this plan; or
- becomes eligible for other coverage under the group contract.

You and your dependents can elect this continuation in lieu of or following any other continuation offered under this plan. If this continuation is elected, the conversion privilege will not be available.

## **Handicapped Dependent Children** (GR-9N-31-015-01 TX)

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

**Aetna** will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

### **Continuation of Coverage During a Labor Dispute**

This continuation of coverage provision only applies if this plan is subject to a collective bargaining agreement.

If your coverage under this plan would cease because you cease work due to a labor dispute, you can arrange to continue your coverage during your absence from work if the Texas Insurance Code applies. Coverage may continue for up to 6 months.

Continuation will cease when the first of these events occurs:

- You fail to make the required payments to your collective bargaining unit representative.
- Your representative fails to make the required premium payments to **Aetna**.
- You go to work full time for any other employer.
- Any premium due date when less than 75% of the affected employees have elected to continue their coverage.
- The 6 month continuation period ends.

The monthly premium required by **Aetna** for each person's coverage will be the applicable rate in effect on the date you cease work. **Aetna** has the right to change premium rates under the terms of this Plan at any time during this continuation of coverage.

## **Reimbursement to Texas Department of Human Services**

All health expenses payable on behalf of your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify **Aetna** in writing that the following applies and you request such direct payment be made:

- the Texas Department of Human Services is paying benefits for your child under the financial and medical assistance service program administered pursuant to the Human Resource Code; and you either
- have possession of or access to the child pursuant to a court order; or
- are not entitled to possession of or access to the child and are required by the court to pay child support.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Amendment

**Policyholder:** President and Trustees of Bates College  
**Group Policy No.:** GP-869807  
**Rider:** Texas Complaint and Appeals Health Rider  
**Issue Date:** April 7, 2016  
**Effective Date:** This Booklet-Certificate Amendment is effective on January 1, 2016

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

The following Appeals Procedure, Exhaustion of Process and External Review provisions replace the same provisions appearing in your Booklet-Certificate or any amendment or rider issued to you:

## Appeals Procedure

### Definitions

**Adverse Benefit Determination (Decision):** A determination by **Aetna** that the health care services provided or proposed to be provided to the covered person are not **medically necessary** or appropriate, or are **experimental or investigational**.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- Coverage determinations, including Plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not **Medically Necessary**.

**Appeal:** An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

**Claim Subject to Preauthorization:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Complaint:** Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a course of treatment that was previously approved.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a previously approved course of treatment.

**Experimental or Investigational:** With regard to an **adverse benefit determination**, this means a service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

**Final Adverse Benefit Determination:** An **adverse benefit determination** that has been upheld by Aetna at the exhaustion of the appeals process.

**Post-Service Claim:** Any claim that is not a “**Claim Subject to Preauthorization**.”

## Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse benefit determination** is required.

### Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

### Time Frames for Adverse Benefit Determination Notifications

*If the claim is being denied for post-stabilization care requested by the treating physician or other health care provider following Emergency Medical Care, (an "urgent claim"):*

**Aetna** will notify the treating **physician** or other health care provider within one hour of notification of the request.

*If the patient is hospitalized at the time the claim is made (an "urgent claim"):*

**Aetna** will make notification by telephone or electronic transmission of a claim decision as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

If more information is needed to make a decision in either of these two circumstances described, above, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The **claimant** has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the **claimant** within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

*If the patient is not hospitalized at the time the claim is made:*

**Aetna** will make notification of a claim decision within three working days, in writing, to the provider of record and the patient.

*In all other circumstances, other than as described in the sections, above or below:*

**Aetna** will make written notification of an **adverse benefit determination** within the time appropriate to the circumstances relating to the delivery of the services and to the patient's condition.

### Contents of Notifications

If it is an **adverse benefit determination** **Aetna** will send notice of that determination accompanied by the following:

- (1) the principal reasons for the **adverse benefit determination**;
- (2) the clinical basis for the **adverse benefit determination**;

- (3) a description of or the source of the criteria used as the guideline in making the **adverse benefit determination**; and
- (4) a description of the procedure for the appeal process, including notice of the covered person's right to appeal an **adverse benefit determination** to an independent External Review Organization and of the procedures to obtain that review. If the covered person has a life-threatening condition, you the covered person have the right to an immediate independent External Review. **Aetna's** appeal process in this circumstance is not required.

### **Concurrent Care Claim Extensions, Reductions or Terminations**

If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, **Aetna** will make notification by telephone or electronic transmission of a claim decision of regarding concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within two working days.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

### **Post-service Claims**

**Aetna** will make notification of a post-service claim decision as soon as possible but not later than 30 calendar days after the post-service claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies the covered person within the first 30 calendar day period. If this extension is needed because **Aetna** needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

### **Complaints**

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you, or the person you authorize to do so must write **Aetna** Customer Service. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

### **Appeals of Adverse Benefit Determinations**

You may submit an **Appeal** if **Aetna** gives notice of an **adverse benefit determination**. It will also provide an option to request an external review of the **adverse benefit determination**. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to **Aetna**.

Your appeal may be submitted orally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of **Aetna's** notice of an **adverse benefit determination**;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send in your appeal to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the toll-free telephone number listed on such notice.

**Aetna** will acknowledge receipt, in writing, of your **appeal** within 5 working days of receiving it.

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

### **Group Health Claims**

The review of an appeal of an **adverse benefit determination** shall be provided by an **Aetna** physician not involved in making the **adverse benefit determination**.

### **Non-Expedited Appeals**

**(Applies for Claims Subject to Preauthorization and Post-Service Claims)**

#### **Claims Subject to Preauthorization**

**(May Include Concurrent Care Claim Reduction or Termination)**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

If an **adverse benefit determination** concerning specialty care is upheld upon appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. The **adverse benefit determination** will be reviewed by a provider in the same or similar specialty as that which is the subject of the **adverse benefit determination** and the review will be complete within 15 working days of its receipt of the request.

### **Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

### **Expedited Appeals**

***(Applies for Claims for Post-Stabilization Care following an Emergency or for Claims When the Patient is Hospitalized -- May Include Appeals Regarding Concurrent Care Claim Reductions or Terminations of Hospital Stays)***

Aetna shall issue a decision on the appeal of an **adverse benefit determination** for an Urgent Care Claim within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the Appeal has been received by **Aetna**. If **Aetna** has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is an urgent claim, you may immediately appeal **Aetna's adverse benefit determination** to an independent External Review Organization. You are not required to first comply with **Aetna's appeals** process. Please see the section entitled "External Independent Review", below.

### **External Independent Review**

If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician**, selected by an independent External Review Organization, who has expertise in the problem or question involved.

You may request a review by an independent External Review Organization assigned to the appeal by the Texas Department of Insurance for any appeal related to an **adverse benefit determination** concerning a claim subject to preauthorization involving a decision that the service, supply, or non-formulary drug is **experimental** or **investigational** and/or is not **medically necessary**.

If your **adverse benefit determination** is for a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust **Aetna's** internal appeals processes.

The claim denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits.

### **Expedited Reviews**

An expedited review is possible if either (a) or (b), below applies:

- (a) You have an urgent claim, as described above. The External Review Organization will inform both you and **Aetna** of the decision within four business days or fewer, (depending on the urgency of the medical specifics of the case), from the date of receipt of the request for the expedited External Review of the urgent claim. If the External Review Organization provides an oral notification, it must follow that oral communication with a written notice of the decision within 48 hours of the oral notification.
- (b) Your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Such expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

**Aetna** will abide by the decision of the External Review Organization.

**Aetna** is responsible for the cost of the external review.

For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

#### **Important Note:**

If **Aetna** does not meet all of the **appeal** timeline requirements outlined above, you are considered to have exhausted the **appeal** requirements and may proceed with an **External Review**.

### **Exhaustion of Process**

Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

You may not:

- contact the Texas Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with the Texas Department of Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna Life Insurance Company**; or any matter within the scope of the **Appeals Procedure**:

- (1) before the 61st day after the date written proof of loss is filed as required under the policy; or
- (2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.

A handwritten signature in black ink, appearing to read 'Mark T. Bertolini', with a stylized flourish at the end.

Mark T. Bertolini  
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company  
(A Stock Company)

Rider: Appeals  
Issue Date: April 7, 2016

For certain types of services and supplies, you will be responsible for any copayment shown in this *Schedule of Benefits*. The plan will pay for covered expenses, up to the maximums shown. You are responsible for any expenses incurred over the maximum limits outlined in this *Schedule of Benefits*. You may be billed for any copayment or coinsurance amounts, or any non-covered expenses that you incur.

# Schedule of Benefits

(GR-9N S-01-001-01)

**Employer:** President and Trustees of Bates College

**Group Policy Number:** GP-869807

**Issue Date:** April 7, 2016

**Effective Date:** January 1, 2016

**Schedule:** 4A

**Cert Base:** 4

For: Aetna Vision Preferred

**Notice to Buyer: This certificate provides vision benefits only.**

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Schedule of Aetna Vision Preferred Benefits (GR-9N-S-24-015-01 ME)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Routine Eye Exam</b>	\$20 per visit copay	100% per visit
Maximum Benefit per Routine Eye Exam	Unlimited	\$20
Maximum number of Routine Eye Exams per 12 months	1	1

**Schedule of Aetna Vision Preferred Benefits** (GR-9N-S-24-020-01 ME)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Vision Eyewear Lenses</i></b>		
Single Vision lenses (2 lenses)	\$20 copay	100%
Maximum Benefit for single vision lenses once per 12 months	Unlimited	\$15
Bifocal Vision lenses (2 lenses)	\$20 copay	100%
Maximum Benefit for bifocal vision lenses once per 12 months	Unlimited	\$30
Trifocal Vision lenses (2 lenses)	\$20 copay	100%
Maximum Benefit for trifocal vision lenses once per 12 months	Unlimited	\$60
Lenticular Vision lenses (2 lenses)	\$20 copay	100%
Maximum Benefit for lenticular vision lenses once per 12 months	Unlimited	\$60
Standard Progressive (2 lenses)	*	100%
Maximum Benefit for Standard Progressive vision lenses once per 12 months	*	\$30
<b>*Please refer to your Booklet-Certificate Cover Page for information.</b>		
Premium Progressive (2 lenses)	*	100%
Maximum Benefit for Premium Progressive vision lenses once per 12 months	*	\$30
<b>*Please refer to your Booklet-Certificate Cover Page for information.</b>		

### Contact Lenses

Conventional (2 lenses)	100%	100%
Maximum Benefit for conventional lenses once per 12 months	\$105	\$75
Disposable contacts (per set)	100%	100%
Maximum Benefit for disposable lenses once per 12 months	\$105	\$75

Contact lenses needed to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.	100%	100%
Maximum Benefit for contact lenses per lifetime	Unlimited	\$200

### Schedule of Aetna Vision Preferred Benefits (GR-9N-S-24-030-01 ME)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Vision Eyewear - Frames	100%	100%
Maximum Benefit for one set of frames per 24 months	\$100	\$50

### Expense Provisions (GR-9N S-09-05 01)

#### The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

#### Keep This Schedule of Benefits With Your Booklet-Certificate.

### Copayment Provisions (GR-9N S-09-05 01)

#### Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

## **General** *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.