151 Farmington Ave
Hartford, CT, 06156

Date: January 17, 2022

We make it easy for you to make informed health care decisions

Dear Aetna Member:

You'll find your Summary of Coverage/Schedule of Benefits and your booklet on your secure member website. These documents have the details of your health care benefits. You'll also learn about your share of the costs and which services are covered.

Just log in to your secure member website on **www.aetna.com**. And select "Coverage & Benefits."

We provide free aids and services to people with disabilities to help them communicate effectively with us. If you need these services, just contact the number on your ID card.

What happens if I change plans or coverage?
You can always rely on your secure member website to display the most up-to-date versions of the Summary of Coverage/Schedule of Benefits and your booklet.

If you don't have access to the Internet or would prefer a paper copy, please contact your employer's benefits office.

Sincerely,
Aetna

Preferred Provider Organization (PPO)
Vision Plan

Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder:	President and Trustees of Bates College
Group policy number:	GP-0869807-A
	Schedule of Benefits: 1A
Group policy effective date:	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	January 17, 2022
Plan revision effective date:	January 1, 2022

Underwritten by Aetna Life Insurance Company in the state of Maine.

Schedule of benefits

This schedule of benefits lists the **eligible vision services** and supplies, Benefit Period frequency limits, maximums, if any, that apply to the services you get under this plan.

How to read your schedule of benefits

- You are responsible for full payment of any vision care services you receive that are not a **covered benefit** or that exceed your Benefit Period frequency limit.
- This plan also has a **maximum allowance** for specific **covered benefits**. These are dollar amount maximums for **covered benefits**.

How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at www.aetna.com.
- Call Member Services at the toll-free number on your ID card.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on your plan copayment or maximum benefit when the service or supply is provided, not when payment is made. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Eligible vision services	In-network coverage	Out-of-network coverage
Vision examination		
Routine eye exam	$20 **copayment**	$20 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 visit	

Standard plastic prescription lenses		
Single Vision	$20 **copayment**	$15 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Bifocal	$20 **copayment**	$30 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Trifocal	$20 **copayment**	$60 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Lenticular	$20 **copayment**	$60 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Standard progressive	$85 **copayment**	$30 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Premium progressive	$85 **copayment** then the plan pays up a $120 **maximum allowance**	$30 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Frames		
	$130 **maximum allowance**	$65 **scheduled limit**
Maximum benefit per 24 consecutive month period	1 frame	

Contact Lenses		
Conventional contact lenses	$130 **maximum allowance**	$90 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Disposable contact lenses	$130 **maximum allowance**	$104 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Non-conventional (**medically necessary**) **contact lenses**	$0 **copayment**	$200 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	

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

Preferred Provider Organization (PPO)
Vision Plan

Booklet-Certificate

Prepared exclusively for:

Policyholder:	President and Trustees of Bates College
Group policy number:	GP-0869807-A
	Booklet-certificate: 1
Group policy effective date:	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	January 17, 2022
Plan revision effective date	January 1, 2022

Notice to Buyer: This certificate provides vision benefits only

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Underwritten by Aetna Life Insurance Company in the state of Maine

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan in network and out of network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible vision services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** ("**Aetna**") and your **policyholder**. Ask the **policyholder** if you have any questions about the **group policy**.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your **Aetna** plan of coverage.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

Table of Contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical vision language that is familiar to **vision providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – vision care services. These are **eligible vision services**.
- Pay less cost share when you use a **network provider**.

1. **Eligible vision services**
   So what are **eligible vision services**? They are vision care services that meet these three requirements:
   - They appear in the *Eligible vision services under your plan* section.
   - They are not listed in the *What your plan doesn't cover – eligible vision service exclusions* section.
   - They are not beyond any limits in the schedule of benefits.

2. **Providers**
   Our network of **vision providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **vision provider directory**. Just log into your secure member website at www.aetna.com.

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

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

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

Your in-network coverage means:

- You are responsible for any **copayment** shown in the schedule of benefits.
- The plan will pay for **covered expenses**, up to the maximum shown in the schedule of benefits. You are responsible for any expenses over the maximum.

3. **Paying for eligible vision services– sharing the expense**
   Generally your plan and you will share the expense of your **eligible vision services** when you meet the general requirements for paying.

   But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

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

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

Your out-of-network coverage:

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

You will find details on:

- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

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

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

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

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card

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

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

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

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

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

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At any time
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for vision benefits, you may have to wait until the next annual enrollment period to join.

The following replaces the provision with the same name appearing in the *Who the plan covers* section of your booklet-certificate:

Who can be on your plan (who can be your dependent)

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets any **policyholder** rules and requirements under state law
- Your dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren

- Adopted children including any children placed with you for adoption
- Foster children
- Children you are responsible for under a qualified medical support order or court-order
- Grandchildren in your legal custody

Effective date of coverage

Your coverage will be in effect at 12:01 a.m. on the member effective date.

Important note: You may continue coverage for a disabled child past the age limit shown above. See *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your **policyholder** when benefits for your spouse will begin:
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If we received your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be a dependent)* section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your **policyholder**.
  - Ask your **policyholder** when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.

- A foster child – A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
    - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
    - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
    - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your declaration of domestic partnership with your stepchild's parent.
    - Ask your **policyholder** when benefits for your stepchild will begin. It is the date of your marriage or declaration of domestic partnership or the first day of the month following the qualifying event date.

Inform us of any change

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

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

Special times you and your dependents can join the plan

You can enroll in these situations when:

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

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

Effective date of coverage

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

Eligible vision services under your plan

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

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

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

Eye exam

Eligible vision services include:

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

Vision care services and supplies

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

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

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

What your plan doesn't cover – eligible vision service exclusions

We already told you about the many vision care services and supplies that are eligible for coverage under your plan in the *Eligible vision services under your plan* section. In that section, we also told you that some vision care services and supplies have exceptions. For example, **cosmetic** surgery is never covered. This is an exception.

In this section we tell you about the exceptions that apply to your plan.

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

Exclusions

The following are not **eligible vision services** under your plan except as described in the *Eligible vision services under your plan* section of this booklet-certificate, or by a rider or amendment included with this booklet-certificate:

Cosmetic services and plastic surgery

- Any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons

Court-ordered services and supplies

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

Diabetic care

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

Examinations

Any vision examinations needed:

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

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

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

Other primary payer

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

Personal care, comfort or convenience items

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Treatment in a federal, state, or governmental entity

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

Vision care services and supplies

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

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible vision services**, the foundation for getting covered care is the network. This section tells you about **network providers** and **out-of-network providers**.

Network providers

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

You may select a **network provider** from the **directory** or by logging on to our website at www.aetna.com. You can search our online **directory** for names and locations of **vision providers**.

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

We will tell you what we have paid for **eligible vision services** and supplies. We will tell you if you owe any amounts or if any services or supplies are not covered. You can receive this from us by e-mail or through the mail.

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible vision services** from an **out-of-network provider.** If you use an **out-of-network provider** to receive **eligible vision services**, you will pay more.

You will have to submit claims for treatment received from **out-of-network providers**.

What the plan pays and what you pay

Who pays for your **eligible vision services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **copayments**
- Your out of network scheduled limit
- Your **maximum allowance** listed in your schedule of benefits.

We also remind you that sometimes you will be responsible for paying the entire bill - for example, if you get care that is not an **eligible vision service**.

Special financial responsibility

You are responsible for the entire expense of cancelled or missed appointments.

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

How your copayment works

Your **copayment** is the amount you pay for **eligible vision services**. Your schedule of benefits shows you which **copayment** you need to pay for specific **eligible vision services**.

How your out-of-network scheduled limit works

This means that the plan reimburses a benefit up to the scheduled limit.

How your maximum allowance works

The **maximum allowance** is the most your plan will pay for **eligible vision services** incurred by a covered person per **Benefit Period**. You are responsible for any amounts above the **maximum allowance**.

Important note:
See the schedule of benefits for any **copayments, maximum allowance**, scheduled limits and visit limits that may apply.

You might not have to pay a "surprise bill"

You try to stay in the network, knowing you'll pay less out of pocket. Then you get a bill you didn't expect. The services were covered. But you went outside the network without even knowing it.

That can happen when your **vision provider** uses a lab that is not in the network. The **vision provider** may be in the network. The plan may have approved the service. But you still get a bill. It's because some of the services you received were from a lab that is not in the network. You can tell the **vision provider** to use only network services. But that's not always possible. When you have no choice, you should only have to pay the same amount as when you do stay in the network. Call Member Services to let them know about any surprise bills you may receive.

It is not a surprise bill when you knowingly *choose* to go outside the network. In this case, you will have to pay it.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible vision services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **vision provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **vision provider** or to you as appropriate. You can request a claim form from us and we will provide it within 15 days.

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us. We will provide the form within 15 days • The claim form will provide instructions on how to complete and where to send the form	• You must send us notice and proof within 90 days. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges • Any vision documentation you received from your **vision provider**
Proof of claim When you have received a service from an eligible **vision provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us notice and proof within 90 days
Benefit payment	• Written proof must be provided for all benefits • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

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

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves vision care services you have already received.

Type of notice	Post-service claim
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Adverse benefit determinations

Sometimes we pay only some of your claim. And sometimes we deny payment entirely. Any time we deny even part of the claim, that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

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

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

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

An appeal

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

Appeals of adverse benefit determinations

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

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

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

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

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

Timeframes for deciding appeals

The chart below shows a timetable view of the type of notice and how much time we have to tell you about our decision.

Type of notice	**Post-service appeal**
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Exhaustion of appeals process

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

- Contact the Maine Bureau of Insurance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Maine Bureau of Insurance.
- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- The **group policy** ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium** payment
- We end your coverage
- You become covered under another vision plan offered by your **policyholder**

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by your **policyholder** and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage may continue, until stopped by your **policyholder**, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your **policyholder** and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by your **policyholder** but not beyond 30 months from the start of the absence.

Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by your **policyholder** but not beyond 18 months from the start of the absence.

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

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The **group policy** ends
- You do not make the required **premium** contribution toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your insured dependents if you die?

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

Why would we end you and your dependent's coverage?

We will give you 31 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your **policyholder** any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their vision coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to **policyholders** of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	**Covered persons eligible for continued coverage**	**Length of continued coverage (starts from the day you lose current coverage)**
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
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 dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree vision coverage and your former **policyholder** files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

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

Policyholder/Group vision plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – policyholder or **Aetna**	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – **policyholder**	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree vision coverage and your former **policyholder** files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – **policyholder** or **Aetna**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA **– policyholder or Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice **– policyholder** or **Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the **policyholder** if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the **policyholder** if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the **policyholder** if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the **policyholder** if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. The **policyholder** has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the **policyholder** within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

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

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

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

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

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

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

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

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

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

Reinstatement due to cognitive impairment or functional incapacity

You may tell us if you would like a representative appointed or changed for notifications. If we discontinue coverage for failure to pay your premium, you or your representative, will receive the notification for termination 10 days before the termination date. You or your representative may submit a request for reinstatement within 90 days of the notice, showing that your failure to pay was due to cognitive impairment or functional incapacity.

We may request medical documentation, at your expense, documenting the diminished capacity.

General provisions – other things you should know

Administrative provisions

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

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

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

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

Coverage and services

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

If a service cannot be provided to you
Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

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

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

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

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

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

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include:

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

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

Some other money issues

Assignment of benefits

- You may assign your benefits directly to your **vision provider**. When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the provider directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **group policy.** This may include:
- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **group policy.**

To request assignment you must complete an assignment form. The assignment form is available from the **policyholder**. The completed form must be sent to us for consent.

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

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

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

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

Glossary

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

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

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

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

Covered benefits
Eligible vision services that meet the requirements for coverage under the terms of this plan.

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

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

Eligible vision services
The vision care services and supplies listed in the *Eligible vision services under your plan* section and not listed or limited in the *What your plan doesn't cover – eligible vision service exclusions* section or in the schedule of benefits**.**

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

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

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

Network provider
A provider listed in the **directory** for your plan or who we otherwise designate as part of the network for your plan.

Out-of-network provider
A provider who is not a **network provider** who does not appear in the **directory** for your plan**.**

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

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

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

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

Scheduled limit

This is the most the plan will pay for an **eligible vision service** provided by an **out-of-network provider**.

Vision provider

Any individual legally licensed to provide vision services or supplies.

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:
526

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.

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.

Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: President and Trustees of Bates College

Group policy number: GP-0869807-A

Effective date: January 1, 2022

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

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

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. For all health coverages, benefits will be paid within 30 days following receipt of written proof to support the claim.

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

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

Amendment: Illinois Vision ET
Issue Date: January 17, 2022

Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: President and Trustees of Bates College

Group policy number: GP-0869807-A

Effective date: January 1, 2022

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

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

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

Υπηρεσιες 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 (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν 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 servizio 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 dilficuldades 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 услугами 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 linea 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 (idantifíkasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl 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

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ພະແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຢູ່ທີ່ປາກົດເທິງບັດປະຈຳ ໂອສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະ ລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ພະແນກບໍລິການລູກຄ້າບອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິງສຽງບໍ່ຄ່ອຍໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

ៈសេវាកម្មផ្នែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់ អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្នែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្នែកសេវាកម្មនៃអតិថិជនរបស់ Aetna **មានមធ្យោបាយរកសេវាកម្មបកប្រែ តាមរយៈខ្សែទូរស័ព្ទភាសា** AT&T **។ លេខ** TDD# **សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។**

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。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 هويتك 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 للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

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

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.

Which Plan Pays First

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows**:**

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.
- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:

    1. Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies.
       If a person is covered under a motor vehicle policy and incurs expenses or requires services as a result of an accident with a motor vehicle:

A. Personal Injury Protection (PIP) is the **primary plan** for the first $2,000 of expenses. After that, **plans** will coordinate benefits in accordance with these coordination of benefits provisions.

PIP refers to the personal injury protection coverage included in a motor vehicle liability insurance policy.

B. MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy. MedPay will always be secondary to and in excess of any other **plan** or PIP.

2. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the **plan** that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, member, subscriber or retiree is secondary and the other **plan** is primary.

3. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:

A. The **primary plan** is the **plan** of the parent whose birthday is earlier in the year if:

i. The parents are married or living together whether or not married;

ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.

- If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage , the order of benefits is:

  - The **plan** of the **custodial parent**;
  - The **plan** of the spouse of the **custodial parent**;
  - The **plan** of the non**custodial parent**; and then
  - The **plan** of the spouse of the non-**custodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

4. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired, or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

6. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, member, or subscriber longer is primary.

7. If the preceding rules do not determine the **primary plan**, the allowable expenses shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **This Plan** will not pay more than it would have paid had it been primary.]

Thirty-One Day Continuation

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.

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

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

Amendment: Massachusetts Vision ET
Issue Date: January 17, 2022

BENEFIT PLAN

Prepared Exclusively for
President and Trustees of Bates College

Missouri Aetna Vision Preferred
Extraterritorial Rider

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™

Table of Contents

Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: President and Trustees of Bates College

Group policy number: GP-0869807-A

Effective date: January 1, 2022

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

Important note:

- This amendment will make no change that results in coverage that is not fully compliant with Missouri law.
- The following applies only if you live in the State/Commonwealth of Missouri. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

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.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.
- A determination that the service or supply is **cosmetic**.

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

Authorized Representative: An individual who represents you in an internal complaint or grievance review process who is any of the following:

- A person to whom you have given express, written consent to represent you in an internal complaint or grievances process;
- A person authorized by law to provide substituted consent for you.

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

Expedited Grievance: An expedited Grievance which a medical condition for which the delay caused by a standard Grievance review timeframe could:

- jeopardize your life or health, or
- jeopardize your prognosis or ability to gain maximum function.

If a **Physician** with knowledge of Your medical condition determines a Grievance to meet the definition of an Expedited Grievance, the Grievance must be treated as an Expedited Grievance.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna.**

Full and Fair Review of Claim Determinations and Grievance

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. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you and to your **provider**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **network provider** you must call or 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.

Grievance of Adverse Benefit Determinations

You may submit a **grievance** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one or two levels of **grievances**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your Level One **Grievance**. Your **grievance** must be submitted in writing and must include:

- Your name, date of birth and address.
- Member ID number.
- The Policyholder's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **grievance**.

- Any other information you would like to have considered.

Send your written **grievance** to the address shown on the notice of **adverse benefit determination**, or you may call in your **grievance** using the telephone number listed on the notice.

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

Expedited Grievance

If Your Grievance requires a quicker decision or action by Us because of the urgency of Your medical condition, then You, Your authorized representative, Your **Primary Care Physician (PCP),** or Your treating **physician** may submit an Expedited Grievance by phone or fax by calling the Customer Service number on the back of Your Member ID Card.

We will make a decision on Your Urgent Care Grievance as soon as possible, taking into account the medical exigencies of the case, but not later than 72 hours after we receive Your Expedited Grievance. We will also send You a written confirmation within three (3) working days after Our decision.

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

Your **grievance** should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know in writing within 10 working days that we received your **grievance**. We will then review your **grievance** and provide you with a written response within 20 working days of receiving the **grievance.** We will let you know if we need more information to make a decision and will complete our investigation within 30 working days after we receive all the information we need.

We will make a determination on your **grievance** within the timeframes listed in the chart below. We will tell you in writing about our decision and explain this decision in terms that are clear and specific. In addition, we will inform you of your right to submit a second grievance.

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

Type of notice	**Urgent care/emergency care grievance**	**Pre-service grievance**	**Post-service grievance**
Grievance determinations at each level (us)	36 hours We will confirm our decision in writing within 3 working days of the initial decision	15 calendar days or 5 days after our investigation is complete (whichever is earlier).	20 working days* or 5 days after our investigation is complete (whichever is earlier).

Extensions	None	None	30 calendar days

***** If we cannot make a decision within the timeframe listed, we will send you a letter telling you why. We will however make a decision within 30 calendar days thereafter.

Level Two Grievances

If **Aetna** upholds an **adverse benefit determination** at the first level of **grievance**, you or your authorized representative has the right to file a Level Two **Grievance**. The **grievance** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Grievance**.

Review of a Level Two **Grievance** of an **adverse benefit determination** of a claim shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

You may at any time contact the Missouri Department of Insurance at:

Missouri Department of Insurance,
Financial Institutions and Professional Registration
Consumer Services Section
P. O. Box 690
Jefferson City, Missouri 65102-0690
Consumer Hotline: 800-726-7390
TDD: (573) 526-4536

You are encouraged to exhaust the applicable Level One and Level Two processes of the Grievance Procedure before you:

- 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 Grievance Procedure.

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

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

Amendment: Missouri Vision ET
Issue Date: January 17, 2022

Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: President and Trustees of Bates College

Group policy number: GP-0869807-A

Effective date: January 1, 2022

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

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

Cost Sharing

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**.

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

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

Amendment: Montana Vision ET
Issue Date: January 17, 2022

Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: President and Trustees of Bates College

Group policy number: GP-0869807-A

Effective date: January 1, 2022

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

Important note: The following applies only if you live in the State/Commonwealth of New York. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

Payment of Benefits

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.

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

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

Amendment: New York Vision ET
Issue Date: January 17, 2022

Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: President and Trustees of Bates College

Group policy number: GP-0869807-A

Effective date: January 1, 2022

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

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
Teléfono gratuito: 1-888-416-2277
En línea: www.aetna.com
Correo electrónico: aetnamemberservices@aetna.com
Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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 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.

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

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.

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

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

Amendment: Texas Vision ET
Issue Date: January 17, 2022

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Policyholder:	President and Trustees of Bates College
Group Policy No.:	GP-0869807-A
Rider:	Texas Complaint and Appeals Health Rider
Issue Date:	January 17, 2022
Effective Date:	This Booklet-Certificate Amendment is effective on January 1, 2022

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.

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

Rider: Appeals
Issue Date: January 17, 2022

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

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

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

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY: 711

To access language services at no cost to you, call 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojį' hólne' 1-888-982-3862. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-982-3862। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-982-3862 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862. (Chamorro)

ᏀᎽᏍᏗ ᏚᏬᏂᎯᏍᏗ ᏅᏩᎾᏏᏯᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏱᎩ, ᏫᏴᎯᏏᏔᏯᏏ 1-888-982-3862. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-888-982-3862. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862. (Gujarati)

No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。(Japanese)

လာတ်ကမၤန့ၣ်ကျိဉ်အတ်မၤစၢၤအတ်ဖဲ:တ်မၤတဖဉ်လၢတအိဉ်ဒီး:အပူၤလၢကဘဉ်ဟုဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး: 1-888-982-3862 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-982-3862. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-888-982-3862. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສຽຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862मा टेलफिोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wɛ̈ɛ̈r de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਕਸਿੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-888-982-3862. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862. (Swahili)

[illegible]

(Syriac-Assyrian) 1-888-982-3862

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-888-982-3862. (Yiddish)

Lati wọnú awọn isẹ̀ èdè l'ọfẹ fun ọ, pe 1-888-982-3862. (Yoruba)