BENEFIT PLAN

Prepared Exclusively for
University of Rochester

Aetna Vision Preferred

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

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

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

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Table of Contents

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

Preface *(GR-9N-02-005-01 NY)*

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

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

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

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

Group Policyholder:	University of Rochester
Group Policy Number:	GP-804712
Effective Date:	January 1, 2019
Issue Date:	October 20, 2018
Booklet-Certificate Number:	2

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When Your Coverage Begins

(GR-9N-29-005-02 NY)

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

Who Can Be Covered

Employees

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

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

Eligible Classes

You are in an eligible class if:

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

Determining When You Become Eligible *(GR-9N-29-005-02 NY)*

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

On the Effective Date of the Plan

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

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01-NY)*

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

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

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

Coverage for Domestic Partner *(GR-9N 29-010 01-NY)*
A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  1. Registration as a domestic partnership or, in the case of retirees living outside the city, an alternate affidavit of domestic partnership;
  2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof);
  3. Evidence of two or more of the following:
     - A joint bank account.
     - A joint credit card or charge card.
     - Joint obligation on a loan.
     - Status as an authorized signatory on the partner's bank account, credit card or charge card.
     - Joint ownership of holdings or investments.
     - Joint ownership of residence.
     - Joint ownership of real estate other than residence.
     - Listing of both partners as tenants on the lease of the shared residence.
     - Shared rental payments of residence (need not be 50/50).
     - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence.
     - A common household, and shared household expenses (need not be 50/50).
     - Shared household budget for purposes of receiving government benefits.
     - Status of one as representative payee for the other's government benefits.
     - Joint ownership of major items of personal property (appliances, furniture).
     - Joint ownership of a motor vehicle.
     - Joint responsibility for child care (e.g., school documents, guardianship).
     - Shared child expenses (need not be 50/50).
     - Execution of wills naming each other as the executor and/or beneficiary.
     - Designation as beneficiary under the other's life insurance policy.
     - Designation as beneficiary under the other's retirement benefits account.
     - Mutual grant of durable power of attorney.
     - Mutual grant of authority to make health care decisions (e.g., health care power of attorney).
     - Affidavit by creditor or other individual able to testify to partner's financial interdependence.
     - Other items of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Coverage for Dependent Children *(GR-9N-29-005-02 NY)*
To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 26, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

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

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

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

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

How and When to Enroll *(GR-9N 29-015 03 NY)*

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

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

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

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

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

When Your Coverage Begins *(GR-9N-29-025-01 NY)*

Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- The date any required evidence of good health is approved by Aetna; and
- The date your required contribution is received by **Aetna**.

Your Dependent's Effective Date of Coverage

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

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

Requirements For Coverage *(GR-9N-09-005-01 NY)*

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:
   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

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

Clinical Review Criteria Requests

If you or your covered dependent needs additional information on a specific clinical issue, you may request a clinical review criteria by submitting written request to Aetna. The written request must contain the following information:

- Person's name; address; and telephone number.
- A request for the clinical review criteria; which Aetna would utilize in making a coverage determination involving a specific condition, treatment or device.

The written request should be sent to the following address:

Aetna
CRC Requests - Mail Code: F074
3 Independence Way
Princeton, NJ 08540

Aetna will take into consideration the person's individual situation in applying the clinical review criteria.

For questions, or further assistance, the person should call the Customer Services toll-free telephone number shown on the Identification Card.

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

In case of a denial of coverage, you have full advantage of all appeal rights available under New York State insurance law.

Your Aetna Vision Expense Plan *(GR-9N-22-005-02 NY)*

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

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

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

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

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

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

About the Aetna Vision Preferred Expense Plan

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

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

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

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

Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefits* section and the *Schedule of Benefits* to determine if any services are limited to network coverage only.

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

Availability of Providers

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

Ongoing Reviews

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

How Your Plan Works

Accessing Network Providers and Benefits

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

Cost Sharing For Network Benefits

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

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

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

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

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

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

Cost Sharing for Out-of-Network Benefits

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

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

Comprehensive Vision Expense Plan *(GR-9N-24-005-02 NY)*

What the Plan Covers

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

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

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

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

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

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

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

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

Covered expenses also include

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

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

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

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

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

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

Benefits for Vision Care Supplies After Your Coverage Terminates
If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

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

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

Vision Plan Exclusions *(GR-9N-28-030-02-NY)*

Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician**. The plan covers only those services and supplies that are included in the *What the Plan Covers* section. Charges made for the following are **not** covered. In addition, some services are specifically limited or excluded. This section describes expenses that are **not** covered or subject to special limitations.

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

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

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

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

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

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

Drugs or medicines.

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

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

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

Miscellaneous charges for services or supplies including:

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

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

For an eye exam which:

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

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

Acuity tests.

Prescription or over-the-counter drugs or medicines.

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

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

Anti-reflective coatings.

Tinting of eyeglass lenses.

Duplicate or spare eyeglasses or lenses or frames for them.

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

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

Special supplies such as nonprescription sunglasses and subnormal vision aids.

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

Services to treat errors of refraction.

Vision services that are covered in whole or in part:

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

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

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

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 3 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

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

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

Coverage for your dependents will end if:

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

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

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

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

Continuation of Coverage *(GR-9N-31-015-05 NY)*

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

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

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

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

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

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

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

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

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

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

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

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

Your child is fully handicapped if:

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

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 90 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

COBRA Continuation of Coverage *(GR-9N-31-025-01 NY)*

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

Continuing Coverage through COBRA

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

You or your dependents will need to:

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

Who Qualifies for COBRA

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

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

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

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

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

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

If There Are Multiple Qualifying Events.

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

Determining Your Premium Payments for Continuation Coverage

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

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

When You Acquire a Dependent During a Continuation Period

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

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

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

When Your COBRA Continuation Coverage Ends

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

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is neither disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

General Provisions *(GR-9N-32-005-02-NY)*

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

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

Additional Provisions *(GR-9N-32-005-03-NY)*

The following additional provisions apply to your coverage:

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

Assignments *(GR-9N-32-005-01 NY)*

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

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

Misstatements *(GR-9N-32-005-03-NY)*

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

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

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

Incontestability

As to Accident and Health Benefits:

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

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

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

Health Coverage

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

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

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

Reporting of Claims

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

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

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

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

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than: (a) 30 days of receipt of a claim transmitted electronically or via the internet; or (b) 45 days for a claim submitted by other means. Written proof must be provided for all benefits.

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

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

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

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

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

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Glossary

(GR-9N 34-005 01-NY)

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

A *(GR-9N-34-005-05)*

Aetna

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

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

Coinsurance

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

Copay or Copayment

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

Covered Expenses

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

D *(GR-9N 34-020 06)*

Deductible

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

Directory

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

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

Hospital
This means a short-term, acute, general hospital which:

- Is primarily engaged in providing, by or under the continuous supervision of **physicians**, to inpatients, diagnostic services and therapeutic services for diagnostic, treatment and care of injured and sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a **physician** or dentist;
- Provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861k of U.S. Public Law 89-97 (42 USCA 1395x(k));
- Is duly licensed by the agency responsible for licensing such hospitals;
- Makes charges; and
- Is not, other than incidentally, a place for rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

I *(GR-9N 34-045 01-NY)*

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

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

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

M *(GR-9N-34-065-03 NY)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

O *(GR-9N-34-075-01 NY)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

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

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

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

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

P *(GR-9N-34-080-05 NY)*

Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

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

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

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

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

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

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

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

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

Confidentiality Notice

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

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

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

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

Additional Information Provided by

University of Rochester

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:
University of Rochester Postdoctoral Benefits

Employer Identification Number:
16-0743209

Plan Number:
Refer to your Plan Administrator for this information

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
University of Rochester
200 Wallis Hall Box 270021
Rochester, NY 14627
Telephone Number: (585) 273-1619

Agent For Service of Legal Process:
University of Rochester
200 Wallis Hall Box 270021
Rochester, NY 14627

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 Deputy of the Provost.

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.

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

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

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

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

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

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

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

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

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

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

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

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

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Policyholder:	University of Rochester
Group Policy No.:	GP-804712
Rider:	New York Complaint and Appeals Health Rider
Issue Date:	October 20, 2018
Effective Date:	January 1, 2019

Complaint and Appeals - Health Coverage

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

Appeals Procedure

Definitions

Adverse benefit determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit because it is determined to be experimental or investigational or not medically necessary or appropriate.

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

- Your eligibility for coverage ;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **medically necessary**, based on the information provided).

If applicable, denials of out-of-network claims on the basis that an out-of-network service is not materially different than an in-network service shall not constitute an **adverse benefit determination**.

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

Health care provider: A health care professional or facility licensed pursuant to New York law or licensed, registered or certified by another state.

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

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services.

Expedited Appeal: Appeal of an **adverse benefit determination** involving (1) continued or extended health care services, procedures and treatments or additional services for a covered person undergoing a course of continued treatment prescribed by a health care provider, or (2) an **adverse benefit determination** in which the health care provider believes an immediate appeal is warranted where there is imminent or serious threat to the health of the insured, except any retrospective determination.

Grievance: A request for review of a determination, other than a determination meeting the definition of **adverse benefit determination**.

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

Post-Service Claim: Any claim that is not a "Concurrent Care Claim Extension," an "Urgent Care Claim" or a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the person or the ability of the person to regain maximum function; or (b) in the opinion of a physician with knowledge of the person's medical condition would subject the person to severe pain that cannot be adequately managed without the requested treatment.

Out-of-Network Denial: A denial of a request for preauthorization to receive a health service from an out-of-network provider on the basis that such service is not materially different from a health service available in-network. The Notice of denial of such out-of-network service shall include information explaining what information must be submitted to appeal the denial.

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of a claim determination as soon as possible, but not later than 72 hours after receipt of the necessary information.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days. Aetna will notify you or your designee and your **Health Care Provider** of the determination by telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination by telephone and in writing to you, your designee and your **health care provider** as soon as possible, but no later than 24 hours after receipt of the necessary information.

Post-service Claims

Aetna will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days.

The Notice of **adverse benefit determination** will include:

- The reasons for the **adverse benefit determination**, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the plan's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions on how to start the appeals, expedited appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse**
- **benefit determination**. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on **appeal**.

In the event that Aetna renders an **adverse benefit determination** without first attempting to discuss the matter with the insured's **health care provider** who specifically recommended the service, procedure or treatment, the **health care provider** will have the opportunity to request a reconsideration of the adverse benefit determination. Except for post-service claims, such reconsideration will occur within
one business day of receipt by Aetna of the request. If the **adverse benefit determination** is upheld, Aetna will provide notice, as described above.

If Aetna does not render a decision within the period set forth above, you may consider this to be an **adverse benefit determination**, subject to **appeal**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an **in-network provider (if applicable)** you must call or 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 15 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.

By calling Customer Service. Aetna's Customer Service telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

Appeals of Out-of-Network Denials (if applicable)

You may appeal an out-of-network denial based on the fact that an alternate service is available in-network by submitting:

- a written statement from your **physician** that the service is materially different from the health service the plan approved to treat your medical needs
- two documents from available medical and scientific evidence, stating that such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for 1two levels of **appeal**. 2It will also provide an option to request an external review of the **adverse benefit determination.**

You have 180 calendar days with respect to Group Health and Group Disability claims and 60 calendar days with respect to all Other Group claims following the receipt of notice of an **adverse benefit determination** to request your 1level one **appeal**. Your **appeal** may be submitted orally or in writing. The request should include:

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

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

You may also choose to have an authorized designee make the **appeal** on your behalf by providing written consent to Aetna. Your **health care provider** may make the appeal in connection with the **adverse benefit determinatio**n for a **post service claim**.

Level One Appeal – Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be decided by Aetna personnel not involved in making the **adverse benefit determination**.

Expedited Appeals

Aetna has established an expedited **appeals** process for adverse **benefit determinations** involving **urgent care** claims, **concurrent care claim extensions** and **pre-service claims**. Aetna will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within 36 hours of receipt of the necessary information to conduct the **appeal**.

Standard Appeals

Aetna shall issue a decision within 30 calendar days of receipt of the necessary information to conduct the **appeal**. Aetna will provide written acknowledgement of the filing of the **appea**l within 15 days of its receipt.

The notice of the appeal determination will include:

- If the **adverse benefit determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of your right to an external appeal, together with information and a description of the external **appeals** process. You also have the option to request a Level 2 **appea**l from Aetna.

If Aetna does not render an appeals determination within 60 days after receipt if the information necessary to conduct the appeal, the adverse benefit determination will be reversed.

Level Two Appeal

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

A level two **appeal** of an **adverse benefit determination** of an **expedited appeal** shall be decided by Aetna personnel not involved in making the **adverse benefit determination**. A level two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the Aetna Appeals Committee.

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)

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

Pre-Service Claims (other than those subject to an Expedited Appeal)

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

Post-Service Claims

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

Grievances

You may submit a **grievance** to Aetna with respect to review of any determination other than an **adverse benefit determination**.

Aetna will acknowledge receipt of the **grievance** within 15 calendar days after its receipt by Aetna.

Grievance Determinations
Expedited Grievances
Aetna will resolve an expedited **grievance** within 36 hours after receipt of all necessary information when delay would significantly increase the risk to a person's health.

Standard Grievances
For other **grievances**, Aetna will acknowledge receipt within 15 calendar days and issue a determination within 30 calendar days after receipt of the **grievance**, but not later than 45 days after receipt of all necessary information**.**

Grievance Appeals
Expedited Grievances
Aetna will render a decision within 36 hours after receipt of the appeal.

Standard Grievances
Aetna will acknowledge receipt within 15 calendar days and issue a determination within 30 calendar days after receipt of the appeal**.**

External Review

Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the a)service is not medically **necessary** or is an experimental or investigational treatment 1 or (b) if applicable, such service is out-of network and an alternate is available in-network, you may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination that a Service is not Medically Necessary

If Aetna has denied coverage on the basis that the service is not medically **necessary**, you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal **appeal** process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal **appeal**.

In addition, your attending **physician** must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **physician**, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending **physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this plan or one for which there exists a clinical trial (as defined by law.)

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

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

Your Right to Appeal a Determination that an Alternate Service is available In-Network (if applicable)

If Aetna has denied coverage on the basis that an alternate service is available in-network (other than a clinical trial, which is covered immediately above), you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial, or you and Aetna must agree in writing to waive any internal
- The attending **physician** certifies that such out-of -network service is (i) materially different than the alternate in-network service; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased

For the purposes of this section, your attending **physician** must be a licensed, board certified or board eligible **physician** qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If, through the first level of Aetna's internal **appeal** process, you have received a final **adverse benefit determination** upholding a denial of coverage on the basis that the service is not medically **necessary** or is an experimental or investigational treatment, or (if applicable) an alternate service is available in-network, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal **appeal**, you have 45 days from the receipt of such waiver to file a written request for an external **appeal**. Aetna will provide an external appeal application with the final **adverse benefit determination** issued through the first level of Aetna's internal **appeal** process or its written waiver of an internal **appea**l.

You may also request an external **appeal** application from the New York State Department of Insurance at 1-800-400-8882. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If you satisfy the criteria for an external **appeal**, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited **appeal** (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of the completed application. The External Appeal Agent may request additional information from you, your **physician** or Aetna. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending **physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external **appeal**. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not medically **necessary** or approves coverage of an experimental or investigational treatment or determines that the out-of-network service (if applicable) should be covered under the Plan, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your responsibility to initiate the external **appeals** process. You may initiate the external **appeal** process by filing a completed External Appeal application with the New York State Department of Insurance. You or your designee may file an external **appeal** application; but if it's filed by your designee, you must consent to it in writing. The Department of Insurance may request from you written confirmation of the appointment of a designee. In addition, your attending **physician** has the right to pursue an external **appeal** of a retrospective **adverse claim determination**. To do so, the attending **physician** must complete an External Appeal application for health care providers. You must sign an acknowledgment of the request and a consent to release of any medical records.

Under New York State law, the completed request for **appeal** must be filed within 45 days of either: the date upon which you receive written notification from Aetna that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal **appea**l. Aetna has no authority to grant an extension of this deadline.

Covered Services and Exclusions

In general, this plan does not cover experimental or investigational treatments. However, this plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.

APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR PERSONS DIAGNOSED WITH ADVANCED CANCER

The following applies if a person: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the person's participating provider); and (ii) the participating provider, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the person's care would be appropriately provided by such facility.

In the event **Aetna** disagrees with the admission of or provision or continuation of care of the person by the facility, **Aetna** must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and **Aetna** will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

Aetna will keep records of your complaint for 7 years.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)