BENEFIT PLAN

Prepared Exclusively For
Caraday Healthcare, LLC

Aetna Vision Preferred

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

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

Preferred Provider Organization (PPO)
Vision Plan

Booklet-Certificate

Prepared exclusively for:

Policyholder:	Caraday Healthcare, LLC
Group policy number:	GP-175291
Booklet-certificate:	1
Group policy effective date:	August 1, 2021
Plan effective date:	August 1, 2021
Plan issue date:	June 24, 2021

The insurance policy under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Underwritten by Aetna Life Insurance Company in the state of Texas

Have a complaint or need help?

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

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

Aetna, Inc.

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

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

The Texas Department of Insurance

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

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

¿Tiene una queja o necesita ayuda?

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

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

Aetna, Inc.

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

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

El Departamento de Seguros de Texas

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

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

Preferred Provider Disclosure Notice

- You have the right to an adequate network of preferred **providers** (also known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
  - If you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network **deductible** and out-of-pocket maximum.

- You have the right, in most cases, to obtain estimates in advance:
  - from **out-of-network providers** of what they will charge for their services; and
  - from your insurer of what it will pay for the services.

- You may obtain a current **directory** of preferred **providers** at the following website: www.aetna.com or by calling **Aetna** Member Services at the toll-free number on your ID card for assistance in finding available preferred **providers**. If the **directory** is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

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

- If the amount you owe to an out-of-network **hospital**-based radiologist, anesthesiologist, pathologist, emergency department **physician**, neonatologist, assistant surgeon, out-of-network emergency care **provider** or any out-of-network **provider** working at a network facility is greater than $500 (not including your **copayment**, **coinsurance**, and **deductible** responsibilities) for services received in a network **hospital**, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

Welcome

Thank you for choosing **Aetna**.

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

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

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

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

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

Welcome to your **Aetna** plan.

Table of Contents

Let's get started!

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

Some notes on how we use words

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

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

What your plan does – providing covered benefits

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

How your plan works – starting and stopping coverage

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

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

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

How your plan works while you are covered in-network

Your in-network coverage helps you:

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

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

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

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

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

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

Your in-network coverage means:

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

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

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

How to contact us for help

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

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

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

You can also contact us by:

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

Your member ID card

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

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

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

Who the plan covers

You will find information in this section about:

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

Who is eligible

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

When you can join the plan

As an employee you can enroll yourself and your dependents:

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

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

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

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are your "dependents".)

- Your legal spouse
- Your dependent children – your own or those of your spouse
  - Unmarried and
  - Under age 25, or
  - Over age 25, as long as they are full-time students, at an accredited institution of higher education and solely depends on your support, and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption and any child when you become a party in a suit to adopt the child *
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - A grandchild who, at the time of application, is your dependent for federal tax purposes

* Your adopted child may be enrolled as shown in the *When you can join the plan* section at your option, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

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

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

Effective date of coverage

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

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

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

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin.
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If we receive your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan for the first 31 days after birth.
  - To keep your newborn covered, you must notify us, verbally or in writing, and we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 31 days after you become party in a suit to adopt the child, the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.
- A foster child - A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.

- A stepchild - You may put a child of your spouse on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage with your stepchild's parent.
  - Ask your **policyholder** when benefits for your stepchild will begin. It is the date of your marriage or the first day of the month following the qualifying event date.
- Children you are responsible for under a qualified medical support order or court order (whether or not the child resides with you) – A child you are responsible for under such a support order is automatically enrolled for the first 31 days after we receive such order or notice of such order.
  - To keep your child covered, you must complete enrollment information within 31 days after we receive such order or notice of such order from your employer.
  - If you miss this deadline, your child will not have vision benefits after the first 31 days.

Inform us of any changes

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

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

Special times you and your dependents can join the plan

You can enroll in these situations when:

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

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

Effective date of coverage

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

Eligible vision services under your plan

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

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

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

Eye exam

Eligible vision services include:

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

Vision care services and supplies

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

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

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

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

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

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

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

Exclusions

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

Cosmetic services and plastic surgery

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

Court-ordered services and supplies

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

Diabetic care

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

Examinations

Any vision examinations needed:

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

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

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

Other primary payer

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

Personal care, comfort or convenience items

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Treatment in a federal, state, or governmental entity

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

Vision care services and supplies

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any vision examination, or any corrective eyewear required by a **policyholder** as a condition of employment, and safety eyewear
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-**prescription** sunglasses
- Two pair of glasses in lieu of bifocals
- Services rendered after the date you and your dependents cease to be covered under the plan, except when vision materials were ordered before coverage ended are delivered, and the services rendered are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would become available

Who provides the care

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

Network providers

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

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

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

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

Out-of-network providers

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

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

What the plan pays and what you pay

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

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

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

Special financial responsibility

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

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

How your copayment works

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

How your out-of-network scheduled limit works

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

How your maximum allowance works

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

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the **policyholder** not later than 20 days after the date of loss. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof within 90 days. • We must send you a claim form within 15 business days of your request. • If the claim form is not sent on or by the 16th day, you are considered to have complied with the requirements for submitting proof of loss. • If you are unable to complete a claim form, you may send us: - A description of services - Bill of charges - Any vision documentation you received from your **vision provider**

Notice	Requirement	Deadline
Proof of loss (claim) When you have received a service from an eligible **vision provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us.	• You must send us notice and proof within 90 days after you have incurred expenses for **covered benefits**. • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• We will accept or reject a claim not later than 15 business days of receiving all items, statements and forms. • Benefits will be paid not later than 5 business days after the date the notice of acceptance is sent. • If we reject the claim the written notice will include the reason for denial. • All benefits payable will be paid no later than 60 calendar days from the date proof of loss is received.

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

Communicating our claim decisions

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

Retrospective claim

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

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

Adverse determinations

Sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse determination". It is also an "adverse determination" if we rescind your coverage entirely.

An **adverse determination** is our determination that the health care services you have received, or may receive, are:

- **Experimental or investigational**
- Not **medically necessary**

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

It is also an **adverse determination** if our determination is based on:

- Your eligibility for coverage
- Your plan's exceptions What your plan doesn't cover – eligible vision service exceptions and exclusions section

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for the denial
- The clinical basis for the denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves a life-threatening condition

The chart below tells you how much time we have to tell you about an adverse determination.

Type of notice	Retrospective review
Initial decision	Within 30 days after the date on which the claim is received
Extensions	15 days
Additional information request (us)	30 days
Response to additional information request (you)	45 days

Important note:
We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell you no later than the times shown in the chart above.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **vison provider** or an operational issue, and you may want to complain. You can call or write Member Services. You compliant should include a description of the issue.

Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But it is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

Your complaint should include a description of the issue. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return. You should include copies of any records or documents that you think are important.

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

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

Appeals of adverse determinations
You can appeal our adverse determination. We will assign your appeal to someone who was not involved in making the original decision.

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

- Your name
- The **policyholder**'s name
- A copy of the adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider
- If you appealed verbally or by phone, we will send you a one page appeal form to be filled out by you or your authorized representative.

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

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

Expedited internal appeal
You are entitled to an expedited internal appeal process for denials of care for life-threatening conditions.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse determination.

Important note:
You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

Timeframes for deciding appeals of adverse determinations

The chart below shows a timetable view of the type of notice and how much time we have to tell you about our decision. We may tell you about our decision verbally or in writing. If we tell you verbally, we will also send you a letter within 3 calendar days after the verbal notice.

Type of appeal	Our response time
Retrospective appeal	As soon as possible but not later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day from the date all information to complete the review is received

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must show good cause for specialty review. The request must be made not later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeals process

In most situations you must complete an appeal with us before you can appeal through an independent review process.

We encourage you to complete an appeal with us before you pursue arbitration, litigation or other type of administrative proceeding.

You do not have to complete the internal appeal process when:

- We did not follow all of the claim determination and appeal requirements of Texas and the Federal Department of Health and Human Services. But, you will not be able to proceed directly to independent review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.
- You have a life-threatening condition. You can have your appeal reviewed through the internal review process.

Independent review

Independent review is a review done by people in an organization outside of **Aetna**. This is called an independent review organization (IRO).

You have a right to independent review only if:

- Our claim decision involved medical judgment.
- We decided the service or supply is not appropriate.
- We decided the service or supply is **experimental or investigational**.
- You have received an adverse determination.

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the request for external review form.

You must submit the Request for Review by an Independent Review Organization (IRO) Form:

- To **Aetna**
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

Aetna will send your independent review request to the Texas Department of Insurance (TDI). The TDI will assign it to an IRO and notify us of the assignment. We will send your request and supporting information to the assigned IRO no later than the third business day after we receive it.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Send notification of the decision.

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

The IRO will notify you of their decision. The amount of time they have to make their decision is based on the services you are requesting. The chart below tells you how much time the IRO has to review your request.

IRO Decisions	
When your request involves:	**The IRO will notify you within:**
Emergency services	72 hours
Prescription drugs or intravenous infusions you are currently receiving	72 hours
Any other service	The earlier of: • 15 days after the IRO receives all necessary information • 20 days after the IRO receives the request

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

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

When coverage may continue under the plan

Your coverage under this plan will continue if:

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

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

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

When will coverage end for any dependents?

Coverage for your dependent will end if:

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

What happens to your insured dependents if you die?

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

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

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

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

Special coverage options after your plan coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

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

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

Qualifying event causing loss of coverage	**Covered persons eligible for continued coverage**	**Length of continued coverage (starts from the day you lose current coverage)**
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree vision coverage and your former **policyholder** files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

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

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

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

How can you extend the length of your COBRA coverage?
The chart below shows qualifying events after the start of COBRA (second qualifying events):

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

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

When is your first premium payment due?
Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

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

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

When does COBRA coverage end?
COBRA coverage ends if:

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

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

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

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

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

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

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support

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

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate
We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws.

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

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

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

Coverage and services

Your coverage can change

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

If a service cannot be provided to you

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

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

Financial sanctions exclusions:

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

Legal action

We encourage you to complete the appeal process before you take any legal action against us for any expense or bill until you complete the appeal process. You cannot take any action until 61 days after we receive written submission of claim.

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

Physical examinations and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

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

We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the booklet-certificate effective date.

In the absence of fraud, any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Some other money issues

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the **provider** directly. If you assign benefits to such a provider, we will pay them directly.

Notice of claim
We must receive your claim within 20 days (or as soon as reasonably possible) after you get a covered medical service. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Proof of loss
We must receive written proof of loss from you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims
We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above for more information.

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

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

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

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

Payment to a conservator, other than you
Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for an **eligible vision service** that you paid

Reimbursement to Texas Department of Human Services

We will repay the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  - Have possession or access to the child through a court order; or
  - Are not entitled to possession of or access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Department of Human Services.

Glossary

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

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

Copay, copayments
The specific dollar amount you have to pay for a vision care service listed in the schedule of benefits.

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

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

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

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

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

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

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

Maximum allowance
This is the most the plan will pay for **eligible vision services**.

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

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

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

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

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

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

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

Aetna Life Insurance Company

Vision amendment

Policyholder: Caraday Healthcare, LLC

Group policy number: GP-175291

Amendment effective date: August 1, 2021

Your vision **group policy** has changed. The schedule of benefits and booklet-certificate are amended to reflect the changes. The changes are effective on the date shown above.

The changes are as follows:

The following replaces the *Prescription lenses* benefit in the *Plan features* section your schedule of benefits:

Standard plastic prescription lenses		
Single Vision	$25 **copayment**	$25 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Bifocal	$25 **copayment**	$40 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Trifocal	$25 **copayment**	$55 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Lenticular	$25 **copayment**	$55 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	

The following replaces the *Contact lens* benefit appearing in the *Plan features* section of your schedule of benefits:

Contact Lenses		
Conventional contact lenses	$150 **maximum allowance**	$120 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Disposable contact lenses	$150 **maximum allowance**	$120 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	

The following replaces the *Medically necessary contact lens* benefit appearing in the *Plan features* section of your schedule of benefits:

Non-conventional (**medically necessary**) **contact lenses**	$0 **copayment**	$200 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	

The following replaces the exclusion with the same name appearing in the *What your plan doesn't cover – eligible vision service exclusions* section of your booklet-certificate:

Vision care services and supplies

These are:

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

- Services or materials provided by any other group benefit plan providing vision care
- Replacement of lost or broken lenses, frames, glasses or contact lenses (except in the next benefit period when you can order new ones)

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

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

If your plan includes coverage for dependents, you can enroll the following family members:

- Your legal spouse
- Your dependent children –yours or your spouse's or partner's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption and any child when you become a party in a suit to adopt the child.*
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody
    - A grandchild who, at the time of application, is your dependent for federal tax purposes
    - A grandchild whose parent is already covered as a dependent on this plan

*Your adopted child may be enrolled as shown in the *When you can join the plan* section at your option, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

The "*Copayment*, *Scheduled limit* and *Maximum allowance"* definitions in your schedule of benefits are deleted. See the "*Copay, copayments*" "*Scheduled limit"* and "*Maximum allowance*" definitions below that apply to your plan.

The "*Copay, copayments*" and "*Maximum allowance*" definitions in the *Glossary* section of your booklet-certificate are deleted and replaced with the following:

Copay, copayments

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

Maximum allowance

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

The following definition is added to the *Glossary* section of your booklet-certificate:

Scheduled limit

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

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

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

Amendment
Issue Date: June 24, 2021

Additional Information Provided by

Caraday Healthcare, LLC

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:
Caraday Healthcare, LLC Welfare Benefit Plan

Employer Identification Number:
84-3394616

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Caraday Healthcare, LLC
102 Whitetail Dr.
San Marcos, TX 78666
Telephone Number: (737) 221-5058

Agent For Service of Legal Process:
Caraday Healthcare, LLC
102 Whitetail Dr.
San Marcos, TX 78666

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

End of Plan Year:
July 31

Source of Contributions:
Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Senior Vice President and/or Human Resources.

ERISA Rights

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

Receive Information about Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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