

BENEFIT PLAN

**Prepared Exclusively For
The City of Seattle**

Basic Vision

**What Your Plan
Covers and How
Benefits are Paid**



Vision Plan

Booklet

Prepared exclusively for:

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Third Party Administrative Services provided by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded health benefit plan.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. 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.

Each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded health benefit plan.

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Schedule of benefits

Issued with your booklet

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 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** when we are describing administrative services provided by **Aetna** as Third Party Administrator.
- 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** for which 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

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

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

You may choose any **vision provider** for the care you need.

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

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 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**
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

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 Employer 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)

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets any Employer rules and requirements under state law
- Your dependent children – yours or your spouse's or partner's
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court-order
 - Grandchildren in your legal custody

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask your Employer 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 domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan. See *Who can be on your plan (Who can be a dependent)* section for more information.
 - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your Employer.
 - Ask your Employer when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan for the first 31 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
 - To keep your adopted child covered, we must receive your completed enrollment information within 31 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 31 days after the date the child is placed with you.
 - If you miss this deadline, your foster child will not have vision benefits after the first 31 days
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
 - Ask your Employer when benefits for your stepchild will begin. It is the date of your marriage or the date of your Declaration of Domestic Partnership or the first day of the month following the qualifying event.

Notification of change in status

It is important that you notify us of any changes in 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 of marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group vision plan

Special times you and your dependents can join the plan

You can enroll in these situations when:

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

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

Effective date of coverage

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

Eligible vision services under your plan

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

You may get vision services and supplies from any **vision providers**. Refer to your schedule of benefits for more information.

You may use **vision providers** of your choice for **eligible vision services** and supplies under this plan.

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**
- Aphakic lenses prescribed after cataract surgery
- 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

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 exclusions. For example, **cosmetic** surgery is never covered. This is an exclusion.

In this section we tell you about the exclusions 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, or by a rider or amendment included with this booklet:

Cornea transplants

- Cornea (corneal graft with amniotic membrane)

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

Examinations

Any vision examinations needed:

- During your stay in a hospital or other facility for medical care
- For the purpose of the fitting of contact lenses
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

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

Other primary payer

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

Personal care, comfort or convenience items

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

Services provided by a family member

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

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
- Services rendered after the date a member ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured member are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible vision services**. This section tells you about **vision providers**.

Vision providers

When you need vision supplies, you can go to any **vision provider** to provide **eligible vision services** and supplies to you.

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 **vision provider**.

We will tell you what we have paid for **eligible vision services** and supplies. It 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.

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 your vision supply maximums 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
- Charges, expenses, or costs in excess of any maximum

Where your schedule of benefits fits in

How your vision supply maximum works

The maximum is the most your plan will pay for **eligible vision services** incurred by a covered person per 12 consecutive month period. You are responsible for any amounts above the maximum.

Important note:

See the schedule of benefits for maximums that apply.

Claim decisions and appeals procedures

In the previous section, we explained how you and the plan 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	<ul style="list-style-type: none"> You should notify and request a claim form from your employer. The claim form will provide instructions on how to complete and where to send the form(s). 	<ul style="list-style-type: none"> You must send us notice and proof as soon as reasonably possible. If you are unable to complete a claim form, you may send us: <ul style="list-style-type: none"> A description of services Bill of charges Any vision documentation you received from your vision provider
<p>Proof of loss (claim)</p> <p>When you have received a service from an eligible vision provider, you will be charged.</p> <p>The information you receive for that service is your proof of loss.</p>	<ul style="list-style-type: none"> A completed claim form and any additional information required by your employer. 	<ul style="list-style-type: none"> You must send us notice and proof as soon as reasonably possible
Benefit payment	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Benefits will be paid as soon as the necessary proof to support the claim is received.

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

Communicating our claim decisions

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

Post-service claim

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

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

Adverse benefit determinations

Sometimes we pay only some of 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 benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

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

The difference between a complaint and an appeal

A Complaint

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

An Appeal

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

Appeals of adverse benefit determinations

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

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

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

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

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

Timeframes for deciding appeals

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

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

Exhaustion of appeals process

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

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

External review

External review is a review done by people in an organization outside of **Aetna**. This is called an External Review Organization (ERO). Sometimes, this is called an Independent Review Organization (IRO).

You have a right to external 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 external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 123 calendar days (four months) of the date you received the decision from us
- 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 ERO. We will pay for information we send to the ERO plus the cost of the review.

Aetna will:

- Contact the ERO that will conduct the review of your claim.
- 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 within 45 calendar days of the date we receive your request form and all the necessary information.

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

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Recordkeeping

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

Fees and expenses

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

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage end 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 contract ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required contributions
- We end your coverage
- You become covered under another vision plan offered by your employer

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 employer and us.	If required contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: <ul style="list-style-type: none"> • Your coverage may continue, until stopped by your employer.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer.	If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: <ul style="list-style-type: none"> • Your coverage will stop on the date that your employment ends.
Your employment ends because: <ul style="list-style-type: none"> • 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 <i>Special coverage options after your plan coverage ends</i> section.
Your employment ends because of a paid or unpaid medical leave of absence	If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: <ul style="list-style-type: none"> • Your coverage may continue until stopped by your employer.
Your employment ends because of a leave of absence that is not a medical leave of absence	If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below: <ul style="list-style-type: none"> • Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence.

Your employment ends because of a military leave of absence.	<p>If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by your employer but not beyond 18 months from the start of the absence.
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It is your employer’s responsibility to let us know when your employment ends. The limits above may be extended only if your employer agrees 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.
- Your group contract ends
- You do not make the required contribution toward the cost of dependents’ coverage.
- Your coverage ends for any of the reasons listed above

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

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

What happens to your 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 dependents 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 employer 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 or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree vision coverage and your former employer files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

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

Employer/Group vision plan notification requirements		
Notice	Requirement	Deadline
General notice – employer or Aetna	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	<ul style="list-style-type: none"> • 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 employer files for bankruptcy 	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer 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 – employer 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 – employer 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 employer if: <ul style="list-style-type: none"> You divorce or legally separate and are no longer responsible for dependent coverage Your covered dependent children no longer qualify as a dependent under the plan 	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the employer if: <ul style="list-style-type: none"> 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 employer if: <ul style="list-style-type: none"> 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 employer if: <ul style="list-style-type: none"> You are electing COBRA 	60 days from the qualifying event. You will lose your right to elect, if you do not: <ul style="list-style-type: none"> 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)
<ul style="list-style-type: none"> You die You divorce or legally separate and are no longer responsible for dependent coverage You become entitled to benefits under Medicare Your covered dependent children no longer qualify as dependent under the plan 	You and your dependents	Up to 36 months

How do you enroll in COBRA?

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

When is your first premium payment due?

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

How much will COBRA coverage cost?

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

Can you add a dependent to your COBRA coverage?

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

- They meet the definition of an eligible dependent.
- You notified the employer 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.

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 and
- Depends mainly (more than 50% of income) on you for support.

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

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

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

General provisions – other things you should know

Administrative information

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 vision plan. This document may have amendments too. Under certain circumstances, we or the customer or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person – including the employer 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 the employer any unearned premium.

Legal action

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

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

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

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

Financial information

Assignment of benefits

When you see a **vision provider** they will usually bill us directly. We may choose to pay you or to pay the **vision provider** directly.

Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

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.

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.

Effective date of coverage

The date you and your dependent's coverage begins under this booklet as noted in your employer's 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.

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.

Prescription

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

Vision provider

Any individual legally licensed to provide vision services or supplies.

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.