

VISION PLAN

Prepared Exclusively for
Ohio Public Employees Retirement System
(OPERS)

Aetna Vision Preferred

What Your Plan
Covers and How
Benefits are Paid



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

Schedule of Benefits

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

Policyholder: Ohio Public Employees Retirement System (OPERS)
Group Policy Number: GP-619353
Issue Date: March 27, 2017
Effective Date: January 1, 2017
Schedule: 1A
Cert Base: 1

For: Aetna Vision Preferred

High Option

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Routine Eye Exam</i>	100% per visit	100% per visit
Maximum Benefit per Routine Eye Exam	Unlimited	\$65
Maximum number of Routine Eye Exams per 12 months	1	1
<i>Contact Lens Exam</i>		
Standard Contact Lens Exam	\$17 per visit copay	100% per visit
Maximum Benefit per Standard Contact Lens Exam	Unlimited	\$23
Maximum number of Standard Contact Lens Exams per 12 months	1	1
Premium Contact Lens Exam	\$62 per visit copay	100% per visit
Maximum Benefit per Premium Contact Lens Exam	Unlimited	\$23
Maximum number of Premium Contact Lens Exams per 12 months	1	1

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Eyewear Lenses</i>		
Single Vision lenses (2 lenses)	100%	100%
Maximum Benefit for single vision lenses once per 12 months	Unlimited	\$45
Bifocal Vision lenses (2 lenses)	100%	100%
Maximum Benefit for bifocal vision lenses once per 12 months	Unlimited	\$60
Trifocal Vision lenses (2 lenses)	100%	100%
Maximum Benefit for trifocal vision lenses once per 12 months	Unlimited	\$80
Lenticular Vision lenses (2 lenses)	100%	100%
Maximum Benefit for lenticular vision lenses once per 12 months	Unlimited	\$150
Standard Progressive (2 lenses)	\$65 copay, then the plan pays 100%	100% up to the applicable Maximum Benefit
Maximum Benefit for Standard Progressive vision lenses once per 12 months	Not Applicable	\$60
Premium Progressive (2 lenses)	After a 20% discount, the plan pays \$120. You are then responsible for the balance plus a \$65 copay.	100% up to the applicable Maximum Benefit
Maximum Benefit for Premium Progressive vision lenses once per 12 months	Not Applicable	\$60

Contact Lenses

Conventional (2 lenses)	100%	100%
Maximum Benefit for conventional lenses once per 12 months	\$240	\$228
Disposable contacts (per set)	100%	100%
Maximum Benefit for disposable lenses once per 12 months	\$240	\$228

Contact lenses needed to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.	100%	100%
Maximum Benefit for contact lenses per lifetime	Unlimited	\$228

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Eyewear - Frames	100%	100%
Maximum Benefit for one set of frames per 12 months	\$130	\$78

Low Option

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Routine Eye Exam</i>	100% per visit	100% per visit
Maximum Benefit per Routine Eye Exam	Unlimited	\$50
Maximum number of Routine Eye Exams per 12 months	1	1
<i>Contact Lens Exam</i>		
Standard Contact Lens Exam	\$32 per visit copay	100% per visit
Maximum Benefit per Standard Contact Lens Exam	Unlimited	\$8
Maximum number of Standard Contact Lens Exams per 12 months	1	1
Premium Contact Lens Exam	\$77 per visit copay	100% per visit
Maximum Benefit per Premium Contact Lens Exam	Unlimited	\$8
Maximum number of Premium Contact Lens Exams per 12 months	1	1

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Eyewear Lenses</i>		
Single Vision lenses (2 lenses)	\$5 copay	100%
Maximum Benefit for single vision lenses once per 24 months	Unlimited	\$35
Bifocal Vision lenses (2 lenses)	\$5 copay	100%
Maximum Benefit for bifocal vision lenses once per 24 months	Unlimited	\$55
Trifocal Vision lenses (2 lenses)	\$5 copay	100%
Maximum Benefit for trifocal vision lenses once per 24 months	Unlimited	\$75

Lenticular Vision lenses (2 lenses)	\$5 copay	100%
Maximum Benefit for lenticular vision lenses once per 24 months	Unlimited	\$100

Standard Progressive (2 lenses)	\$70 copay, then the plan pays 100%	100% up to the applicable Maximum Benefit
Maximum Benefit for Standard Progressive vision lenses once per 24 months	Not Applicable	\$55

Premium Progressive (2 lenses)	After a 20% discount, the plan pays \$120. You are then responsible for the balance plus a \$70 copay.	100% up to the applicable Maximum Benefit
Maximum Benefit for Premium Progressive vision lenses once per 24 months	Not Applicable	\$55

Contact Lenses

Conventional (2 lenses)	\$10 copay	100%
Maximum Benefit for conventional lenses once per 24 months	\$200	\$180
Disposable contacts (per set)	\$10 copay	100%
Maximum Benefit for disposable lenses once per 24 months	\$200	\$180

Contact lenses needed to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.	100%	100%
Maximum Benefit for contact lenses per lifetime	Unlimited	\$180

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Eyewear - Frames	100%	100%
Maximum Benefit for one set of frames per 24 months	\$50	\$44

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

The following provisions apply to your health expense plan.

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

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

Keep This Schedule of Benefits With Your Booklet-Certificate.

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

Copayment, Copay

This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

General (GR-9N-28-01-01-OH)

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

SUPPLEMENT

HIGH OPTION

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	\$65 copay
Premium Progressives as Follows:	
Tier 1	\$85 copay
Tier 2	\$95 copay
Tier 3	\$110 copay
Tier 4	\$65 copay, 80% of charge less \$120 Allowance

Anti-Reflective Coating Price List*	Member Cost In-Network
Standard Anti-Reflective Coating	\$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	\$57
Tier 2	\$68
Tier 3	80% of charge

Other Add-ons Price List	Member Cost In-Network
Photochromic (Plastic)	\$75
Polarized	80% of charge

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

For a current list of brands by tier, go to:

<http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf>

SUPPLEMENT

LOW OPTION

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
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Standard Progressive	\$70 copay
Premium Progressives as Follows:	
Tier 1	\$90 copay
Tier 2	\$100 copay
Tier 3	\$115 copay
Tier 4	\$70 copay, 80% of charge less \$120 Allowance

Anti-Reflective Coating Price List*	Member Cost In-Network
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Standard Anti-Reflective Coating	\$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	\$57
Tier 2	\$68
Tier 3	80% of charge

Other Add-ons Price List	Member Cost In-Network
---------------------------------	-------------------------------

Photochromic (Plastic)	\$75
Polarized	80% of charge

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

For a current list of brands by tier, go to:

<http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf>

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

Preface (GR-9N-02-005-01 OH)

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

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

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

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

Group Policyholder:	Ohio Public Employees Retirement System (OPERS)
Group Policy Number:	GP-619353
Effective Date:	January 1, 2017
Issue Date:	March 27, 2017
Booklet-Certificate Number:	1



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

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

Who Can Be Covered

Eligible Beneficiaries

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

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

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are an eligible beneficiary of OPERS, and you:
 - are receiving or are eligible to receive a monthly pension check from OPERS; and
 - qualify for health care benefits.

Determining When You Become Eligible (GR-9N-S-29-005-02-OH)

You become eligible for the plan on your eligibility date, which is the date determined in accordance with the rules established and promulgated by OPERS.

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

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

- Your legal spouse; and
- Your dependent children.

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

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your legally adopted children;
- Any children for whom you are responsible under court order;

- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

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

Important Reminder

Keep in mind that you cannot receive coverage under the plan as:

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

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

Initial Enrollment in the Plan

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

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

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

Annual Enrollment

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

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

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

Your Effective Date of Coverage

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

- The date you are eligible for coverage; or
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**

Important Notice:

You must pay the required contribution in full.

Your Dependent's Effective Date of Coverage

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

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

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

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this Booklet-Certificate;
 - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.
2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of medical practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
 - (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
 - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

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

Important Note

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

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

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

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

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

Important Notes:

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

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

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

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

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

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

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

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

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

Availability of Providers

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

Ongoing Reviews

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

How Your Plan Works

Accessing Network Providers and Benefits

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

Cost Sharing For Network Benefits

Important Note:

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

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

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

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

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

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

Cost Sharing for Out-of-Network Benefits

Important Note:

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

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

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

What the Plan Covers

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

Vision Exams

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

- Routine eye exam: A complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.
- Contact lens exam: A contact lens exam performed for the sole purpose of fitting contact lenses.

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

Vision Supplies

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

Prescription Lenses

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

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

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

Covered expenses also include

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

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

Frames

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

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

Limitations

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

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

Benefits for Vision Care Supplies After Your Coverage Terminates

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

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

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

Vision Plan Exclusions

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

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

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

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

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

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

Drugs or medicines.

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

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

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

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;

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

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

For an eye exam which:

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

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

Acuity tests.

Prescription or over-the-counter drugs or medicines.

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

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

Duplicate or spare eyeglasses or lenses or frames for them.

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

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

Special supplies such as nonprescription sunglasses and subnormal vision aids.

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

Services to treat errors of refraction.

Vision services that are covered in whole or in part:

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

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

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

When Coverage Ends for Eligible Beneficiaries (GR-9N-30-005-05 OH)

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by OPERS;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit.

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

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

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends for Eligible Beneficiaries*;
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by OPERS.

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

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

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

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

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

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

COBRA Continuation of Coverage

If OPERS has more than 20 eligible beneficiaries, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

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

You or your dependents will need to:

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

Who Qualifies for COBRA

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

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

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your marriage is annulled, or you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

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

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

If There Are Multiple Qualifying Events.

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

Determining Your Premium Payments for Continuation Coverage

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

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

When You Acquire a Dependent During a Continuation Period

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

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

Important Note

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

When Your COBRA Continuation Coverage Ends

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

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date OPERS no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by OPERS. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, refer to the section of this Booklet-Certificate entitled *Converting to an Individual Policy*. You may also contact your employer or call the toll-free number on your member ID card.

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

Type of Coverage

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

Legal Action

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

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

Confidentiality

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

Additional Provisions

The following additional provisions apply to your coverage.

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

Assignments (GR-9N-32-005-02-OH)

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

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

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

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

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

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

Incontestability

As to Accident and Health Benefits:

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

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

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

Health Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Appeals Procedure (GR-9N-32-050-01-OH)

Definitions

Adverse Benefit Determination (Decision) means:

A decision by **Aetna**:

- To deny, reduce, terminate or fail to provide or make payment in whole or in part, for a service, supply or benefit. Such **adverse benefit determination** may be include all of the following:
 - Your eligibility for coverage.
 - A determination that the health care services does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments.

- A determination of your eligibility for individual health insurance coverage, including coverage offered through a non-employer group, to participate in a plan or health insurance coverage.
- The results of any Utilization Review activities.
- A determination that a health care service is not a covered benefit.
- The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to you, including coverage offered through a non-employer group.
- As to medical and prescription drug claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

Authorized Representative: An individual who represents you in an internal appeal or external review process of an **adverse benefit determination** who is any of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an **adverse benefit determination**;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional, but only when you are unable to provide consent.

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

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

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

Covered Benefits or Benefits: Those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person: Policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. “Covered person” does include the covered person’s **authorized representative** with regard to an internal appeal or external review.

Emergency Services:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

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

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

Health Benefit Plan: A policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Care Services: Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan Issuer: An entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the **superintendent** of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health Plan Issuer” includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the **superintendent**.

Independent Review Organization: An entity that is accredited to conduct independent external reviews of **adverse benefit determinations**.

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

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

Rescission or to rescind: A cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize: The provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

Superintendent: The Superintendent of Insurance.

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

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

Full and Fair Review of Claim Determinations and Appeals

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

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

Claim Determinations

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

Urgent Care Claims

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

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

Complaints

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

Notice of an Adverse Determination

When **Aetna** notifies you of an **adverse benefit determination** in writing, you will also be notified of your right to an **external review**. As part of the written notice, the Plan will include the following:

- Sufficient information to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;
- A description of the reason or reasons for the **adverse benefit determination**, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;
- A description of the available internal **appeals** and **external review** processes, including information regarding how to initiate an **appeal** and an **external review**; and
- Disclosure of the availability of assistance from the **superintendent** with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the **superintendent's** Office of Consumer Services.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** if the services are eligible for external review.

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

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

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

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna** if you decide to choose an authorized representative. You may also supply additional information that you would like us to consider regarding your appeal. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

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

Level One Appeal

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

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

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

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

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

Post-Service Claims

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

Level Two Health Appeal

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

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

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

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

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

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

Post-Service Claims

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

Exhaustion of Process

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

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

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

Exceptions to the exhaustion of the Level One and Level Two processes of the **Appeals** procedure may occur in the following instances:

- a) **Aetna** agrees to waive the Exhaustion requirement;
- b) You did not receive a written decision of **Aetna's** internal **appeal** within the required timeframe;
- c) **Aetna** fails to meet all requirements of the internal appeals process unless the failure:
 - was *de minimis*;
 - does not cause or is not likely to cause prejudice or harm to you;
 - was for good cause and beyond the control of the Plan; or
 - is not reflective of a pattern or practice of non-compliance.
- d) an expedited **external review** is sought simultaneously with an expedited internal review.

An internal **appeal** process shall be considered exhausted if you have requested an internal **appeal** and have not received a written decision from **Aetna** at each level of **appeal** within the timeframes listed above and **Aetna** fails to adhere to all requirements of the internal **appeals** process.

You may not request an **external review** of an **adverse benefit determination** involving a retrospective utilization review decision until **Aetna's** internal **appeal** process has been exhausted unless the **Aetna** agrees to waive the exhaustion requirement

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

Important Note:

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

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

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

Opportunity for External Review (GR-9N-32-051-01-OH)

An **external review** may be conducted by an **Independent Review Organization (IRO)** or by the Ohio Department of Insurance. You do not pay for the **external review**. There is no minimum cost of health care services denied in order to qualify for an **external review**. However, you must generally exhaust the health Plan issuer's internal **appeal** process before seeking an **external review**. Exceptions to this requirement will be included in the notice of the **adverse benefit determination**.

External Review by an IRO

You are entitled to an **external review** by an IRO in the following instances:

- The **adverse benefit determination** involves a medical judgment or is based on any medical information
- The **adverse benefit determination** indicates the requested service is **experimental or investigational**, the requested health care service is not explicitly excluded in your health benefit Plan, and the treating physician certifies at least one of the following:
 - Standard **health care services** have not been effective in improving your condition.
 - Standard **health care services** are not medically appropriate for you.
 - No available standard health care service covered by the Plan is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- Your treating physician certifies that the **adverse benefit determination** involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal **appeal**.
- Your treating physician certifies that the **final adverse benefit determination** involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed until after the time frame of a standard **external review**.
- The **final adverse benefit determination** concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but has not yet been discharged from a facility.

- An expedited internal **appeal** is already in progress for an **adverse benefit determination** of **experimental or investigational** treatment and your treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited **external review** is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to you.)

External Review by the Ohio Department of Insurance

You are entitled to an **external review** by the Department in the either of the following instances:

- The **adverse benefit determination** is based on a contractual issue that does not involve a medical judgment or medical information.
- The **adverse benefit determination** for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND the Plan's decision has already been upheld through an **external review** by an IRO.

Request for External Review

Regardless of whether the **external review** case is to be reviewed by an IRO or the Department of Insurance, you or an **authorized representative**, must request an **external review** through **Aetna** within 180 days of the date of the notice of final **adverse benefit determination** issued by their Plan.

All requests must be in writing, except for a request for an expedited **external review**. Expedited **external reviews** may be requested electronically or orally; however written confirmation of the request must be submitted to **Aetna** no later than five (5) days after the initial request. You will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete **Aetna** will initiate the **external review** and notify you in writing, or immediately in the case of an expedited review, that the request is complete and eligible for **external review**. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform you that, within 10 business days after receipt of the notice, you may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. **Aetna** will also forward all documents and information used to make the **adverse benefit determination** to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete **Aetna** will inform you in writing and specify what information is needed to make the request complete. **Aetna** determines that the **adverse benefit determination** is not eligible for **external review**, **Aetna** must notify you in writing and provide you with the reason for the denial and inform you that the denial may be **appealed** to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for **external review** regardless of the decision by **Aetna** and require that the request be referred for **external review**. The Department's decision will be made in accordance with the terms of the health benefit Plan and all applicable provisions of the law.

IRO Assignment

When the Plan initiates an **external review** by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Aetna, you, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by **Aetna** in making the **adverse benefit determination**, any information submitted by you and other information such as; your medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the health Plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the plan of a request for a standard review or within 72 hours of receipt by the Plan of a request for an expedited review. This notice will be sent to you, **Aetna** and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for **external review**.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the **external review**.
- The dates over which the **external review** was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an **adverse benefit determination** that involves a health care treatment or service that is stated to be **experimental or investigational** also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An **external review** decision is binding on **Aetna** except to the extent that **Aetna** has other remedies available under state law. The decision is also binding on you except to the extent that you have other remedies available under applicable state or federal law.

You may not file a subsequent request for an **external review** involving the same **adverse benefit determination** that was previously reviewed unless new medical or scientific evidence is submitted to the Plan.

If You Have Questions About Your Rights or Need Assistance

You may contact the Plan:

Aetna
National External Review Unit
11675 Great Oaks Way
Alpharetta, GA 30022
Toll Free # (877) 848-5855
Fax #: (860) 975-1526

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

Glossary

(GR-9N 34-005 01)

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

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

Aetna

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

C (GR-9N 34-015 02)

Coinsurance

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

Copay or Copayment

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

Covered Expenses

Vision services and supplies shown as covered under this Booklet-Certificate.

D (GR-9N 34-020 01)

Deductible

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

Directory

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

H (GR-9N 34-040 02)

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and

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

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

I (GR-9N 34-045 02)

Illness

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

Injury

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

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

M (GR-9N-34-065-03 OH)

Medically Necessary or Medical Necessity

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

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

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

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

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

N (GR-9N 34-070 02)

Negotiated Charge

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

Network Provider

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

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

Non-Occupational Illness

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

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

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

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

Non-Occupational Injury

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

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

O (GR-9N-34-075-01 OH)

Occupational Injury or Occupational Illness

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

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

Occurrence

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

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

Out-of-Network Provider

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

P (GR-9N-34-080-05 OH)

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Premium Progressive Lenses

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

Prescriber

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

Prescription

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

Prescription Drug

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

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

R (GR-9N-34-090-01 OH)

Recognized Charge (GR-9N-34-090-01 OH)

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

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

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

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

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

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

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

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

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

Important Note

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

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

Additional Information

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

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

Standard Progressive Lenses

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

Stay

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

Confidentiality Notice

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

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

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

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

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment (GR-9N-CR1)

Policyholder: Ohio Public Employees Retirement System (OPERS)
Group Policy No.: GP-619353
Effective Date: July 27, 2017

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

1. The following section “Coverage for Dependent Children” replaces the section of the same name currently shown in your Booklet-Certificate:

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your legally adopted children;
- Any children for whom you are responsible under court order; and
- Your grandchildren in your court-ordered custody.

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

Important Reminder

Keep in mind that you cannot receive coverage under the plan as:

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

2. The following section “COBRA Continuation of Coverage” replaces the section of the same name currently shown in your Booklet-Certificate:

COBRA Continuation of Coverage

If OPERS has more than 20 eligible beneficiaries, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

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

You or your dependents will need to:

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

Who Qualifies for COBRA

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

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

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your marriage is annulled or 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 dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

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

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

If There Are Multiple Qualifying Events.

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

Determining Your Premium Payments for Continuation Coverage

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

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

When You Acquire a Dependent During a Continuation Period

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

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

Important Note

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

When Your COBRA Continuation Coverage Ends

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

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
 - You or your covered dependents do not pay required premiums.
 - You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
 - The date OPERS no longer offers a group health plan.
 - The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
 - You or your dependent dies.
3. The following section “Appeals Procedure” replaces the section of the same name currently shown in your Booklet-Certificate:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision) means:

A decision by **Aetna**:

- To deny, reduce, terminate or fail to provide or make payment in whole or in part, for a service, supply or benefit. Such **adverse benefit determination** may include all of the following:
 - Your eligibility for coverage.
 - A determination that the health care services does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments.

- A determination of your eligibility for individual health insurance coverage, including coverage offered through a non-employer group, to participate in a plan or health insurance coverage.
- The results of any Utilization Review activities.
- A determination that a health care service is not a covered benefit.
- The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to you, including coverage offered through a non-employer group.
- As to medical and prescription drug claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

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

Authorized Representative: An individual who represents you in an internal appeal or external review process of an **adverse benefit determination** who is any of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an **adverse benefit determination**;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional, but only when you are unable to provide consent.

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

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

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

Covered Benefits or Benefits: Those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person: Policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. “Covered person” does include the covered person’s **authorized representative** with regard to an internal appeal or external review.

Emergency Services:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

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

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

Health Benefit Plan: A policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Care Services: Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan Issuer: An entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the **superintendent** of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health Plan Issuer” includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the **superintendent**.

Independent Review Organization: An entity that is accredited to conduct independent external reviews of **adverse benefit determinations**.

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

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

Rescission or to rescind: A cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize: The provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part.

Superintendent: The Superintendent of Insurance.

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

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

Full and Fair Review of Claim Determinations and Appeals

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

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

Claim Determinations

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

Urgent Care Claims

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

If you file an **appeal**, coverage under the plan will continue for the previously approved ongoing course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection

with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

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

Notice of an Adverse Determination

When **Aetna** notifies you of an **adverse benefit determination** in writing, you will also be notified of your right to an **external review**. As part of the written notice, the Plan will include the following:

- Sufficient information to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;
- A description of the reason or reasons for the **adverse benefit determination**, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;
- A description of the available internal **appeals** and **external review** processes, including information regarding how to initiate an **appeal** and an **external review**; and
- Disclosure of the availability of assistance from the **superintendent** with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the **superintendent's** Office of Consumer Services.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** if the services are eligible for external review.

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

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

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

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna** if you decide to choose an authorized representative. You may also supply additional information that you would like us to consider regarding your appeal. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

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

Level One Appeal

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

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

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

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

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

Post-Service Claims

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

Level Two Health Appeal

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

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

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

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

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

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

Post-Service Claims

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

Exhaustion of Process

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

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

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

Exceptions to the exhaustion of the Level One and Level Two processes of the **Appeals** procedure may occur in the following instances:

- d) **Aetna** agrees to waive the Exhaustion requirement;
- e) You did not receive a written decision of **Aetna's** internal **appeal** within the required timeframe;
- f) **Aetna** fails to meet all requirements of the internal appeals process unless the failure:
 - was *de minimis*;
 - does not cause or is not likely to cause prejudice or harm to you;
 - was for good cause and beyond the control of the Plan; or
 - is not reflective of a pattern or practice of non-compliance.

- d) an expedited **external review** is sought simultaneously with an expedited internal review.

An internal **appeal** process shall be considered exhausted if you have requested an internal **appeal** and have not received a written decision from **Aetna** at each level of **appeal** within the timeframes listed above and **Aetna** fails to adhere to all requirements of the internal **appeals** process.

You may not request an **external review** of an **adverse benefit determination** involving a retrospective utilization review decision until **Aetna's** internal **appeal** process has been exhausted unless the **Aetna** agrees to waive the exhaustion requirement

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

Important Note:

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

There are limits, though, on what sends a claim or **appeal** straight to an **External Review**.

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

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



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

AVP
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