Student Vision Insurance

Preferred Provider Organization (PPO)
Vision Plan

Certificate of Coverage

Prepared exclusively for

Policyholder:	**University of Kentucky**
Policyholder number:	**259940**
Student policy effective date:	**09/01/25**
Plan effective date:	**09/01/25**
Plan issue date:	**12/22/25**

Read your certificate carefully

This certificate is part of a legal agreement between the contract holder and Aetna. We agree to insure you and any other covered dependent listed on the certificate, in return for your premium payments. We will pay eligible covered benefits while this agreement is in force and after the agreement terms have been met.

This cover sheet provides only a brief outline of some of the important features of your certificate of coverage. This cover sheet is not the contract and only the actual certificate of covrage provisions apply. The certificate of coverage describes in detail the rights and obligations of both you and us. It is therefore important that you read your certificate of coverage and schedule of benefits which are a part of this agreement.

Underwritten by Aetna Life Insurance Company in the state of Kentucky
151 Farmington Avenue, Hartford, Connecticut 06156

Welcome

Thank you for choosing **Aetna**.

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

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

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

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

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

Welcome to your **Aetna** plan.

Table of Contents

Let's get started!

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

Some notes on how we use words in the certificate and schedule of benefits

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

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

What your plan does – providing covered benefits

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

How your plan works – starting and stopping coverage

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

Your coverage typically ends when you are no longer a student. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

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

How your plan works while you are covered in-network

Your in-network coverage helps you:

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

1. **Eligible vision services**

   So what are **eligible vision services**? They are vision care services that meet these three requirements:

   - They appear in the *Eligible vision services under your plan* section.
   - They are not listed in the *What your plan doesn't cover – eligible vision service exclusions* section.
   - They are not beyond any limits in the schedule of benefits.

2. **Providers**

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

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

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

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

Your in-network coverage means:

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

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

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

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

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

Your out-of-network coverage:

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

You will find details on:

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

How to contact us for help

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

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

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

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card 877-973-3238
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card

We issued to you a digital ID card which you can view or print by going to the secure website at www.aetnastudenthealth.com. When visiting **vision providers**, you don't need to show them an ID card. Just provide them with your name, date of birth and either your printed ID card or social security number. The vision office can use that information to verify your eligibility and benefits.

If you don't have internet access, call Member Services at the toll-free phone number in the *How to contact us for help* section. You can also access your digital ID card when you're on the go. To learn more, visit us at www.aetnastudenthealth.com.

Remember, only you and your covered dependents can use your digital ID card. If you misuse your card by allowing someone else to use it, that is fraud and we may end your coverage. See the *Honest mistakes and intentional deception* section for details.

Who the plan covers

You will find information in this section about:

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

Who is eligible

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

When you can join the plan

As a student you can enroll yourself and your dependents:

- During the enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

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

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

You can enroll the following family members on your plan. (They are referred to in this certificate as your "dependents.")

- Your legal spouse
- Your civil union partner
- Your domestic partner who meets the rules set by the **policyholder** and requirements under state law
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
  - Under age 26

A dependent does not include an eligible student listed above in the *Who is eligible – When you can join the plan* section.

Adding new dependents

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

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your **policyholder** when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information
    - Within 31 days of the date of your marriage
- A civil union partner - If you enter into a civil union, you can enroll your civil union partner on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your civil union.
  - Ask your **policyholder** when benefits for your partner will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed information
    - Within 31 days of your civil union

- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your **policyholder**.
  - Ask your **policyholder** when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your vision plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the newborn.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - A child that you, or that you and your spouse, civil union partner or domestic partner adopt is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.
- A stepchild - You may put a child of your spouse, civil union partner or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage, civil union partnership, or Declaration of Domestic Partnership with your stepchild's parent.
  - Ask your **policyholder** when benefits for your stepchild will begin. It is either on the date of your marriage, the date of your civil union partnership, or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

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

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- You enroll in any other group vision plan

Special times you and your dependents can join the plan

You can enroll in these situations when:

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

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

Effective date of coverage

Enrollment

Student coverage

If you enrolled on or before the effective date of the **student policy**, you are covered on the effective date of the **student policy.** Your coverage begins only if we received your completed enrollment application you did not waive automatic enrollment in the student plan and you paid any required **premium** contribution.

If you enroll after the effective date of the **student policy**, your coverage begins on the date you enroll as long as:

- We agree
- We receive your completed enrollment request
- You pay any **premium** contribution

Dependent coverage

Your dependent's coverage begins on the date we receive a completed enrollment application and you pay any required **premium** contribution. See the *Adding new dependents* section for details.

Late enrollment

If we receive your enrollment application and **premium** contribution more than 31 days after the date you become eligible, coverage will only become effective if, and when:

- We agree to enroll you
- You enroll during the **policyholder's** late enrollment period, or
- You enroll because you lost coverage for any reason under another vision plan with similar vision coverage

Eligible vision services under your plan

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

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

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

Eye exam

Eligible vision services include:

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

Vision care services and supplies

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

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

In any one **policy year**, this benefit will cover **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

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

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

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

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

Exclusions

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

Cosmetic services and plastic surgery

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

Court-ordered services and supplies

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

Examinations

Any vision examinations needed:

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

Other primary payer

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

Personal care, comfort or convenience items

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

Services provided by a family member

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

Vision care services and supplies

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

Who provides the care

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

Network providers

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

You may select a **network provider** from the **directory** or by logging on to our website at www.aetnastudenthealth.com. You can search our online **directory** for names and locations of **vision providers** or contact Member Services at the toll-free number on your ID card.

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

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

Out-of-network providers

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

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

What the plan pays and what you pay

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

- Your in-network **copayments**
- Your out-of-network **scheduled limits**
- Your out-of-network **deductibles**
- Your in-network **maximum allowances**

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

Special financial responsibility

You are responsible for the entire expense of Cancelled or missed appointments

Neither you nor we are responsible for:

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

Where your schedule of benefits fits in

How your in-network copayment works

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

How your out-of-network scheduled limit works

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

How your in-network maximum allowance works

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

How your out-of-network deductible works

Your out-of-network **deductible** is the amount you need to pay before your plan begins to pay benefits for an **eligible vision service** from an **out-of-network provider**. Your schedule of benefits shows the out-of-network **deductible** amounts that apply to your plan.

Once you have met the **deductible**, we will start sharing the cost with you for the out-of-network **eligible vision service.**

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

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify us in writing within 60 days and request a claim form from us • You can send your written notice of claim to us at Aetna Vision, P.O. Box 8504 Mason, OH 45040-7111 • When we receive your claim, we will send you a claim form within 15 days. If we do not provide you with a claim form within 15 days, you will have complied with any requirements to submit proof of loss. • The claim form will provide instructions on how to complete and where to send the form(s)	• You must send us notice and proof within 90 days • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges – Any vision documentation you received from your **vision provider** – We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.
Proof of claim When you have received a service from an eligible **vision provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us notice and proof within 90 days

Benefit payment	• Written proof must be provided for all benefits • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

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

Communicating our claim decisions

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

Post-service claim

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

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

*Extensions must be agreed upon by both parties.

Adverse benefit determinations

Sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse benefit determination" or "adverse decision."

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

The difference between a complaint and an appeal

A complaint

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

An appeal

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

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

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

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

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

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

Timeframes for deciding appeals

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

Type of notice	**Post-service appeal**
Initial decision by us	30 days
Extensions	None

Exhaustion of appeals process

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

- Contact the Kentucky Department of Insurance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Kentucky Department of Insurance.
- Appeal through an external independent review process.
- Pursue litigation.

Independent review

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

You have a right to independent review only if:

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

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the independent review process. It will include a copy of the Request for Independent Review form at the final adverse determination level.

You must submit the Request for Independent Review form:

- To **Aetna**
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the IRE. You are responsible for a one time filing fee of $25 to be paid to the Independent Review Entity. This fee may be waived if the Independent Review Entity determines that you may incur financial hardship. If the Independent Review Entity finds in your favor and you have paid the one time filing fee, the fee will be refunded to you. We will pay for information we send to the IRE plus the cost of the review.

All of the information regarding your medical records and the independent review process will be treated as confidential. It will not be disclosed to others without your authorization, except in some instances where such disclosure is necessary for the conduct of Aetna's business. Disclosure will not be contrary to any Kentucky law or federal rule or regulation which applies.

Aetna will:

- Contact the Department of Insurance for IRE assignment (eservices)
- Contact the IRE that will conduct the review of your claim.

The IRE will:

- Consider appropriate credible information that you have sent.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Follow the contractual documents and your policy of benefits
- Sent notification of the decision within 21 days of the date they receive the request form and all the necessary information.

An extension of up to 14 calendar days may be allowed if we and you are in agreement.

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

How long will it take to get an IRE decision?
We will tell you of the IRE decision not more than 21 calendar days after we receive your Notice of Internal Review Form with all the information you need to send in.

Recordkeeping

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

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- The **student policy** ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage, including when you are no longer in an eligible class
- The last day for which any required **premium** contribution has been paid
- We end your coverage
- You become covered under another vision plan offered by your **policyholder**
- The date you withdraw from the school because of entering the armed forces of any country

If your coverage ends because you withdraw from school for reasons other than entering the armed forces, we will not refund **premium** contributions. You are covered for the policy term for which you enrolled and paid the **premium** contribution.

If you withdraw from school because you have entered the armed forces, **premiums** will be refunded, on a pro-rata basis, when we receive your request within 90 days from the date of the withdrawal.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent child reaches age 26. Coverage will end on the first **premium** due date following the child's birthday.
- Your dependent is no longer eligible for coverage ,including the date dependents are no longer in an eligible class.
- The **student policy** ends.
- You do not make the required **premium** contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above.

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

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

What happens to your insured dependents if you die?

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

Why would we end your coverage?

We will give you 30 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on loss of coverage.

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate of coverage

We prepared this certificate according to federal and state laws that apply. You and we will follow it according to these laws. Also, you are bound by the laws governing this certificate when we administer your coverage.

How we administer this plan

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

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots. We will try hard to get you access to the services you need even if these things happen.

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

If your student status changes the amount of your coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

A retroactive change in your student status will not cause a retroactive change in your coverage.

If your dependent status changes the amount of your dependent coverage or benefit levels, the change will take effect on the date of the status change and the amount of coverage or benefit level will be changed to the new amount.

Financial sanctions exclusions

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

Legal action

You must complete the appeal process before you take any legal action against us for any expense or bill. See the *When you disagree – claim decisions and appeals procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

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

Records of expenses

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

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

You or your **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 1 year before we learned of it.

Intentional deception

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

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Some other money issues

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider,** we may choose to pay you or to pay the provider directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **student policy.** This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **student policy**

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

Recovery of overpayments

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

Grace period
You will be allowed a grace period of 31 days after the due date for the payment of each contribution due after the first contribution payment. If contributions are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

Premium contribution
This plan requires you to make **premium** contribution payments. We will not pay benefits under this certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Your vision information

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

Glossary

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

Copayment
The dollar or percentage amount that you have to pay to a **network provider** for an **eligible vision service**.

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

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

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

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

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

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

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

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

Policyholder
The school named on the front page of the **student policy** and your certificate of coverage and schedule of benefits for the purpose of coverage under the **student policy**.

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

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

Scheduled limit
This is the most that the plan will pay in a period of time for **eligible vision services** that you incur from an **out-of-network provider**.

Student policy
The **student policy** consists of several documents taken together. These documents are:

- The **policyholder's** application
- Your enrollment form**,** if the **policyholder** requires one
- The **student policy**
- The certificate(s) of coverage
- The schedule of benefits
- Any riders, endorsement, inserts, attachments, and amendments to the **student policy**, the certificate of coverage, and the schedule of benefits

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