Aetna Life Insurance Company

Group Vision
Extraterritorial booklet-certificate amendment

Policyholder: California Institute of Technology

Group policy number: 866280
Group control number: 869106

Effective date: January 1, 2020

This amendment is part of your booklet-certificate that describes your vision coverage. It is effective on the date shown above and it replaces any other vision extraterritorial booklet-certificate amendment you may have received before.

Important note: The following applies only if you live in the State/Commonwealth of Texas. The benefits below will apply instead of those in your booklet-certificate unless the benefits in your booklet-certificate are better.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Aetna's toll-free telephone number for information or to make a complaint at

1-800-MY-Health (694-3258)

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

Premium or Claim Disputes:
Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

Notice:
This notice is for information only and does not become a part or condition of your Policy.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al

1-800-MY-Health (694-3258)

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

Disputas Sobre Primas o Reclamaciones:
Si surge una disputa su concerniente a prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

Aviso:
Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Póliza.

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.aetna.com or by calling 1-800-MY-Health (694-3258) for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

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

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website:

www.tdi.texas.gov/consumer/cpmmediation.html.

Texas Department of Insurance Notice

Coverage for Dependent Children

To be eligible, a dependent child must be:

- Unmarried and under age 25.

To be eligible, a dependent grandchild must be:

- The unmarried child of your child; and
- Under age 25; and
- Supported by you for Federal Income Tax purposes on the date of his or her initial application for coverage. Coverage will not terminate solely due to the child's loss of such Federal Income Tax dependency status; or
- Any age, if medically certified as disabled and dependent on the parent.

Your children can include the following:

- Your biological children;
- Your stepchildren;
- Your legally adopted children; including any child placed with you for adoption and any child for whom you are a party in a suit in which the adoption of the child is sought;
- Your foster children;
- Any child for whom you or your covered spouse is under court order for medical support. This child is covered immediately upon **Aetna**'s notification of such order;
- Any other child who lives with you in a parent-child relationship.

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

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's coverage, if applicable will continue as long as:

- You were covered at the time of your death;
- Your coverage, at the time of your death, is not being continued after your employment has ended;
- A request is made for continued coverage within 60 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 3 year period following your death;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.

Continuation of Coverage for Your Dependents After Your Retirement

If coverage for your dependents would terminate because you retire while covered under any part of this plan, any coverage then in force for your dependents may be continued. Continuation must be requested within 60 days after your retirement. Premium payments for the coverage must be continued.

Your dependent's coverage will not continue beyond the first to occur of:

- The end of a 3 year period starting on the date of your retirement.
- The date a dependent becomes eligible for coverage under any group plan providing health benefits.
- The date dependent coverage under this Plan is discontinued.
- The end of the period for which any required contributions have been made.

If any coverage being continued terminates, the person may apply for a personal policy in accordance with the conversion privilege.

Continuing Health Care Benefits

You may continue coverage under the plan which terminates for you and your dependents, for any reason, except involuntary termination of employment due to cause, but only if you have been covered under this plan for at least 3 months in a row prior to such termination.

You must request the continuation in writing within 31 days of the later to occur of:

- the date coverage would otherwise cease; and
- the date your employer or group policy holder provides you with the notice of your right to continue coverage.

Premium payments must be continued. The required contribution for continued coverage may not exceed 102% of the group rate.

Continuation for a person may not terminate until the earliest of:

- 6 months after the date the election is made.
- The end of the period for which required contributions are made.
- The date the person is or could be covered by Medicare.
- The date the person is covered or is eligible for similar benefits under another medical expense plan.
- The date the person has similar benefits available pursuant to any state or federal law.

Coverage for a dependent will cease earlier when the person:

- ceases to be a defined dependent under this plan; or
- becomes eligible for other coverage under the group contract.

You and your dependents can elect this continuation in lieu of or following any other continuation offered under this plan. If this continuation is elected, the conversion privilege will not be available.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

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.

Continuation of Coverage During a Labor Dispute

This continuation of coverage provision only applies if this plan is subject to a collective bargaining agreement.

If your coverage under this plan would cease because you cease work due to a labor dispute, you can arrange to continue your coverage during your absence from work if the Texas Insurance Code applies. Coverage may continue for up to 6 months.

Continuation will cease when the first of these events occurs:

- You fail to make the required payments to your collective bargaining unit representative.
- Your representative fails to make the required premium payments to **Aetna**.
- You go to work full time for any other employer.
- Any premium due date when less than 75% of the affected employees have elected to continue their coverage.
- The 6 month continuation period ends.

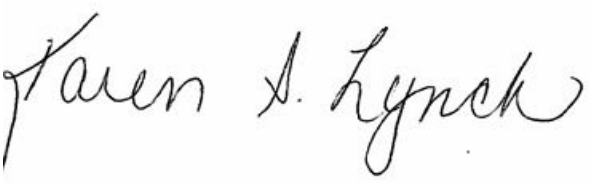
The monthly premium required by **Aetna** for each person's coverage will be the applicable rate in effect on the date you cease work. **Aetna** has the right to change premium rates under the terms of this Plan at any time during this continuation of coverage.

Reimbursement to Texas Department of Human Services

All health expenses payable on behalf of your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify **Aetna** in writing that the following applies and you request such direct payment be made:

- the Texas Department of Human Services is paying benefits for your child under the financial and medical assistance service program administered pursuant to the Human Resource Code; and you either
- have possession of or access to the child pursuant to a court order; or
- are not entitled to possession of or access to the child and are required by the court to pay child support.

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



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Texas Vision ET
Issue Date: December 11, 2019

Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment

Policyholder:	California Institute of Technology
Group Policy No.:	GP-866280
Group Control No.:	CN-869106
Rider:	Texas Complaint and Appeals Health Rider
Issue Date:	December 11, 2019
Effective Date:	This Booklet-Certificate Amendment is effective on January 1, 2020

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.

The following Appeals Procedure, Exhaustion of Process and External Review provisions replace the same provisions appearing in your Booklet-Certificate or any amendment or rider issued to you:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A determination by **Aetna** that the health care services provided or proposed to be provided to the covered person are not **medically necessary** or appropriate, or are **experimental or investigational**.

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

- Your eligibility for coverage;
- Coverage determinations, including Plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not **Medically Necessary**.

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

Claim Subject to Preauthorization: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

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 previously approved course of treatment.

Experimental or Investigational: With regard to an **adverse benefit determination**, this means a service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

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

Post-Service Claim: Any claim that is not a "**Claim Subject to Preauthorization**."

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 benefit 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. 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**.

Time Frames for Adverse Benefit Determination Notifications

If the claim is being denied for post-stabilization care requested by the treating physician or other health care provider following Emergency Medical Care, (an "urgent claim"):

Aetna will notify the treating **physician** or other health care provider within one hour of notification of the request.

If the patient is hospitalized at the time the claim is made (an "urgent claim"):

Aetna will make notification by telephone or electronic transmission of a claim decision as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

If more information is needed to make a decision in either of these two circumstances described, above, **Aetna** will notify the claimant within 24 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 of 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 plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

If the patient is not hospitalized at the time the claim is made:

Aetna will make notification of a claim decision within three working days, in writing, to the provider of record and the patient.

In all other circumstances, other than as described in the sections, above or below:

Aetna will make written notification of an **adverse benefit determination** within the time appropriate to the circumstances relating to the delivery of the services and to the patient's condition.

Contents of Notifications
If it is an **adverse benefit determination Aetna** will send notice of that determination accompanied by the following:

(1) the principal reasons for the adverse benefit determination;
(2) the clinical basis for the adverse benefit determination;
(3) a description of or the source of the criteria used as the guideline in making the adverse benefit determination; and
(4) a description of the procedure for the appeal process, including notice of the covered person's right to appeal an adverse benefit determination to an independent External Review Organization and of the procedures to obtain that review. If the covered person has a life-threatening condition, you the covered person have the right to an immediate independent External Review. Aetna's appeal process in this circumstance is not required.

Concurrent Care Claim Extensions, Reductions or Terminations

If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, **Aetna** will make notification by telephone or electronic transmission of a claim decision of regarding concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within two working days.

If you file an **appeal**, coverage under the plan will continue for the previously approved 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.

Post-service Claims

Aetna will make notification of a post-service claim decision as soon as possible but not later than 30 calendar days after the post-service claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the covered person within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, 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.

Complaints

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

Appeals of Adverse Benefit Determinations

You may submit an **Appeal** if **Aetna** gives notice of an **adverse benefit determination**. It will also provide an option to request an external review of the **adverse benefit determination**. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to **Aetna**.

Your appeal may be submitted orally or in writing and should include:

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

Send in your appeal to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the toll-free telephone number listed on such notice.

Aetna will acknowledge receipt, in writing, of your **appeal** within 5 working days of receiving it.

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.

Group Health Claims

The review of an appeal of an **adverse benefit determination** shall be provided by an **Aetna** physician not involved in making the **adverse benefit determination**.

Non-Expedited Appeals
(Applies for Claims Subject to Preauthorization and Post-Service Claims)

Claims Subject to Preauthorization
(May Include Concurrent Care Claim Reduction or Termination)

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

If an **adverse benefit determination** concerning specialty care is upheld upon appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. The **adverse benefit determination** will be reviewed by a provider in the same or similar specialty as that which is the subject of the **adverse benefit determination** and the review will be complete within 15 working days of its receipt of the request.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Expedited Appeals

(Applies for Claims for Post-Stabilization Care following an Emergency or for Claims When the Patient is Hospitalized -- May Include Appeals Regarding Concurrent Care Claim Reductions or Terminations of Hospital Stays)

Aetna shall issue a decision on the appeal of an **adverse benefit determination** for an Urgent Care Claim within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the Appeal has been received by **Aetna**. If **Aetna** has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is an urgent claim, you may immediately appeal **Aetna's adverse benefit determination** to an independent External Review Organization. You are not required to first comply with **Aetna's appeals** process. Please see the section entitled "External Independent Review", below.

External Independent Review

If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician,** selected by an independent External Review Organization, who has expertise in the problem or question involved.

You may request a review by an independent External Review Organization assigned to the appeal by the Texas Department of Insurance for any appeal related to an **adverse benefit determination** concerning a claim subject to preauthorization involving a decision that the service, supply, or non-formulary drug is **experimental** or **investigational** and/or is not **medically necessary**.

If your **adverse benefit determination** is for a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust **Aetna's** internal appeals processes.

The claim denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits.

Expedited Reviews

An expedited review is possible if either (a) or (b), below applies:

(a) You have an urgent claim, as described above. The External Review Organization will inform both you and **Aetna** of the decision within four business days or fewer, (depending on the urgency of the medical specifics of the case), from the date of receipt of the request for the expedited External Review of the urgent claim. If the External Review Organization provides an oral notification, it must follow that oral communication with a written notice of the decision within 48 hours of the oral notification.

(b) Your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Such expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna will abide by the decision of the External Review Organization.

Aetna is responsible for the cost of the external review.
For more information about the External Review process, call the toll-free Member Services telephone number shown on your ID card.

Important Note:

If **Aetna** does not meet all of the **appeal** timeline requirements outlined above, you are considered to have exhausted the **appeal** requirements and may proceed with an **External Review.**

Exhaustion of Process
Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

You may not:

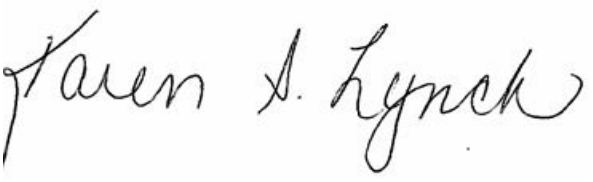
- contact the Texas Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with the Texas Department of Insurance; or
- establish any:

  litigation;
  arbitration; or
  administrative proceeding;

  regarding an alleged breach of the policy terms by **Aetna Life Insurance Company**; or any matter within the scope of the **Appeals Procedure**:

  (1) before the 61st day after the date written proof of loss is filed as required under the policy; or
  (2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Rider: Appeals
Issue Date: December 11, 2019