

*Your
Group
Plan*

Rider University

Passive PPO Dental

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

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract. This Certificate of Coverage is subject to the laws of the state of New Jersey.



Ronald A. Williams
Chairman, Chief Executive Officer, and President

Group Policy: GP-884014
Cert. Base: 4
Issue Date: November 13, 2007
Original Effective Date: January 1, 2007

This Certificate may be an electronic version of the Certificate on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Certificate, please contact your Employer.

0020

Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

0740, 7669, 7672

Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features, and stated maximum benefit amounts. These are all described in the Booklet-Certificate.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

Advance Claim Review

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be \$ 350 or more, it is recommended that the details of the proposed course of treatment and charges be filed in acceptable form with Aetna. Your Employer has the proper forms. Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts.

Advance Claim Review is not recommended for many services. These are routine oral exams, including prophylaxis and X-rays, and treatment of any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment; and
- is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

Note

As a part of Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person. This will be done at no cost to you.
- You must give Aetna all diagnostic and evaluative material which it may require. These include X-rays, models, charts, and written reports.

Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage which applies to:

- Type A expenses;
- Type B expenses; and
- Type C expenses.

3000, 3010, 7673

The benefits payable for charges made by a **Preferred Care Provider** is an amount equal to the Payment Percentage of the **negotiated charge** for the service or supply, after any applicable deductible.

The benefit payable for charges made by a provider that is not a Preferred Care Provider is an amount equal to the Payment Percentage of the Covered Dental Expense, after any applicable deductible.

The Plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses. You are responsible for the deductible.

Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- necessary; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

This Dental Care Schedule includes only services in the list below.

Alternate Treatment

The next sentence applies if:

- a charge is made for an unlisted service given for the dental care of a specific condition; and
- the list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Here is a list of Covered Dental Expenses.

Type A Expenses

VISITS AND X-RAYS

- Office visit during regular office hours, for oral examination
 - Routine comprehensive or recall examination (limited to 2 visits every year)
 - Problem-focused examination (limited to 2 visits every year)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 19)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to two sets per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical x-rays (single films) (up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral

SPACE MAINTAINERS *Includes all adjustments within six months after installation.*

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

PERIODONTICS

- Periodontal maintenance procedures following active therapy (limited to 2 per year)

Type B Expenses

VISITS AND EXAMS

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit
- Collection of microorganisms
- Diagnostic casts
- Therapeutic parenteral drug administration

X-RAY AND PATHOLOGY

- Biopsy and histopathologic examination of oral tissue

ORAL SURGERY

- Extractions
 - Exposed root or erupted tooth
 - Coronal remnants
 - Surgical removal of erupted tooth/root tip
- Impacted Teeth
 - Removal of tooth (soft tissue)
 - Removal of tooth (partially bony)
 - Removal of tooth (completely bony)
- Odontogenic Cysts and Neoplasms
 - Incision and drainage of abscess
 - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
 - Alveoplasty, in conjunction with extractions - per quadrant
 - Alveoplasty, not in conjunction with extraction - per quadrant
 - Sialolithotomy: removal of salivary calculus
 - Closure of salivary fistula
 - Excision of hyperplastic tissue
 - Removal of exostosis
 - Transplantation of tooth or tooth bud
 - Closure of oral fistula of maxillary sinus
 - Sequestrectomy
 - Crown exposure to aid eruption
 - Removal of foreign body from soft tissue
 - Frenectomy
 - Suture of soft tissue injury

PERIODONTICS

- Root planing and scaling, per quadrant, limited to 4 separate quadrants every 2 years
- Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Gingivectomy per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
- Gingival flap procedure, per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Localized delivery of chemotherapeutic agents
- Osseous surgery (including flap entry and closure) - per quadrant (limited to 1 per quadrant, every 3 years)
- Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant (limited to 1 per quadrant, every 3 years)
- Soft tissue graft procedures

ENDODONTICS

- Root canal therapy, including necessary X-rays
 - Anterior
 - Bicuspid

RESTORATIVE DENTISTRY *Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)*

- Amalgam Restorations
- Resin Restorations
- Sedative Fillings
- Pins
 - Pin retention - per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
 - Prefabricated resin crown (excluding temporary crowns)
- Recementation
 - Inlay
 - Crown
 - Bridge
 - Implant
- Full and Partial Denture Repairs
 - Broken dentures, no teeth involved
 - Repair cast framework
 - Replacing missing or broken teeth, each tooth
- Repairs: bridges
- Occlusal guard (for bruxism, or as a periodontal appliance) limited to 1 every 3 years

Type C Expenses

VISITS AND EXAMS

- Internal bleaching - per tooth

PERIODONTICS

- Occlusal adjustment (other than with an appliance or by restoration)
- Provisional splinting

ENDODONTICS

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy, including necessary X-rays
 - Molar

RESTORATIVE *Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.*

- Inlays/Onlays - Metallic or Porcelain/Ceramic
 - Inlay, one or more surfaces
 - Onlay, two or more surfaces
- Inlays/Onlays - Resin-based Composite
 - Inlay, one or more surfaces
 - Onlay, two or more surfaces
- Labial Veneers
 - Laminate-chairside
 - Resin laminate – laboratory
 - Porcelain laminate – laboratory
- Crowns
 - Prefabricated stainless steel
 - Resin
 - Resin with noble metal
 - Resin with base metal
 - Porcelain
 - Porcelain with noble metal
 - Porcelain with base metal

Base metal (full cast)
Noble metal (full cast)
Metallic (3/4 cast)

- Post and core
- Core buildup, including any pins

PROSTHODONTICS

- Bridge Abutments (see Inlays and Crowns)
- Pontics
 - Base metal (full cast)
 - Noble metal (full cast)
 - Porcelain with noble metal
 - Porcelain with base metal
 - Resin with noble metal
 - Resin with base metal
- Removable Bridge (unilateral)
 - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
 - Complete upper denture
 - Complete lower denture
 - Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
 - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
 - Stress breakers
 - Interim partial denture (stayplate), anterior only
 - Office reline
 - Laboratory reline
 - Special tissue conditioning, per denture
 - Rebase, per denture
 - Adjustment to denture more than six months after installation
- Adding teeth to existing full and partial dentures
 - Each tooth
 - Each clasp
- Repairs: crowns
- Implants

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (*only when provided in conjunction with a covered surgical procedure*).

3010, 3010-1, 3010-2, 3010-3, 3010-4, 3020

Explanation of Some Important Plan Provisions

2620, 2630

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

3040

Family Deductible Limit

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

2620, 2630

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. It applies even if there is a break in coverage.

3040

Limitations

3050

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
the service selected must meet broadly accepted national standards of dental practice.

Replacement Rule

The replacement of; addition to; or modification of:

existing dentures;
crowns;
casts or processed restorations;
removable denture;
fixed bridgework; or
other prosthetic services

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast, or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

3050

Exclusions and Limitations

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part:
 - under any other part of this Plan; or
 - under any other plan of group benefits provided by your Employer.
- Those for services and supplies to diagnose or treat a disease or **injury** that is not:
 - a non-occupational disease; or
 - a non-occupational **injury**.
- Those for services not listed in the Dental Care Schedule that applies; except as specifically provided.

- Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for:
 - dentures;
 - crowns;
 - inlays;
 - onlays;
 - bridgework; or
 - other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.
- Those for any of the following services:
 - (a) an appliance, or modification of one, if an impression for it was made before the person became a covered person;
 - (b) a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
 - (c) root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any **jaw joint disorder**; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; except as specifically provided.
- Those for general anesthesia and intravenous sedation; unless done in conjunction with another **necessary** covered service.
- Those for treatment by other than a **dentist**; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.
- Those for a crown; cast; or processed restoration unless:
 - (a) it is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
 - (b) the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

1330-1, 3050-1, 3060, 3070

Benefits After Termination of Coverage

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information section.

Expenses incurred for the following after the person's coverage ceases under this benefit section will be deemed to be incurred when ordered:

- Dentures.
- Fixed bridgework.
- Crowns.

This applies only if the item is finally installed or delivered no more than 30 days after coverage ends.

"Ordered" means:

- impressions have been taken from which the dentures, crowns, or fixed bridgework will be made; and
- as to fixed bridgework and crowns; the teeth must have been fully prepared if:

- they will serve as retainers or support; or
- they are being restored.

3070

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician or dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician or dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

if required by the FDA, approval has not been granted for marketing; or

a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

Furthermore, this exclusion will not apply with respect to non-approved indications for FDA approved drugs if the indication is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:

the American Medical Association Drug Evaluations;

the American Hospital Formulary Service Drug Information;

the United States Pharmacopeia Drug Information;

or, it is recommended by a clinical study or review article in a major peer-reviewed professional journal.

- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a national government or agency or under a state or provincial government or agency. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.)

- Those for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically provided in your Booklet-Certificate.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.

5000, 7409, 7410, 7411

- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:

in the calendar year of the accident which causes the injury; or

in the next calendar year.

Facings on molar crowns and pontics will always be considered cosmetic.

This exclusion does not apply to services or supplies of a cosmetic nature needed in the care and treatment of medically diagnosed congenital defects and birth abnormalities that are provided to dependent children from the moment of birth covered under the Policy.

1330-1, 3050-1, 5000, 7409, 7410, 7411, 9341, 7665

- Those to the extent they are not **recognized charges**, as determined by Aetna; except that this will not apply if the charge for a service or supply does not exceed the **recognized charge** for that service or supply by more than the amount or percentage specified in the Summary of Coverage as the Allowable Variation.

5000, 7409, 7410, 7411, 7549, 9341, 7665, 7665-1

- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

5000, 7409, 7410, 7411, 9341, 7665

Effect of Benefits Under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

The words shown below have special meanings when used in this section. Please read these definitions carefully.

"Allowable Expense" means the charge for any health care service, supply or other item of expense for which the employee is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When **This Plan** is coordinating benefits with a **Plan** that provides benefits only for dental care, vision care, prescription drugs or hearing aids, **Allowable Expense** is limited to like items of expense.

Aetna will not consider the difference between the cost of a private **Hospital** room and that of a semi-private **Hospital** room as an **Allowable Expense** unless the stay in a private room is **Medically Necessary**.

When **This Plan** is coordinating benefits with a **Plan** that restricts **COB** to a specific coverage, **This Plan** will only consider corresponding services, supplies or items of expense to which **COB** applies as an **Allowable Expense**.

"Claim Determination Period" means a calendar year or portion of a calendar year, during which an employee is covered by **This Plan** and at least one other **Plan** and incurs one or more **Allowable Expense(s)** under such **Plans**.

"Coordination of Benefits (COB)" means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

"Plan(s)" means coverage with which **COB** is allowed. **Plan** includes:

- i. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- ii. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- iii. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- iv. Group hospital indemnity benefit amounts that exceed \$150 per day;
- v. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

"Plan(s)" shall not include:

- i. Individual or family insurance contracts or subscriber contracts;
- ii. Individual or family coverage through an HMO or under any other prepayment, group practice and individual practice plans;
- iii. Group or group-type coverage where the cost of the coverage is paid solely by the employee except when coverage is being continued pursuant to Federal or State continuation law;
- iv. Group hospital indemnity benefit amounts of \$150.00 per day or less;
- v. School accident-type coverage;
- vi. A State plan under Medicaid.

"This Plan" is the part of this **Certificate** that provides benefits for health care expenses.

“Primary Plan(s)” means a **Plan** whose benefits for a covered person’s health care coverage must be determined without taking into consideration the existence of any other **Plan**. There may be more than one **Primary Plan**. A Plan will be the **Primary Plan** if:

- i. the **Plan** has no order of benefit determination rules, or it has rules that differ from those contained in this **Certificate**; or
- ii. all Plans which cover the covered person use order of benefit determination rules consistent with those contained in this **Certificate** and under those rules, the Plan determines its benefit first.

“Reasonable Charge” means an amount that is not more than the usual or customary charge for the service or supply as determined by **This Plan**, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

“Secondary Plan(s)” means a **Plan** which is not a **Primary Plan**. If a covered person is covered by more than one **Secondary Plan**, the order of benefit determination rules of this **COB** section shall be used to determine the order in which the benefits payable under the multiple **Secondary Plans** are paid in relation to each other. The benefits of each **Secondary Plan** may take into consideration the benefits of the **Primary Plan** or **Plans** and the benefits of any other **Plan** which, under this **Certificate**, has its benefits determined before those of that **Secondary Plan**.

Primary and Secondary Plan:

This Plan considers each **Plan** separately when coordinating payments.

The **Primary Plan** pays or provides services or supplies first, without taking into consideration the existence of a **Secondary Plan**. If a **Plan** has no **COB** provision, or if the order of benefit determination rules differ from those set forth in this **Certificate**, it is the **Primary Plan**.

A **Secondary Plan** takes into consideration the benefits provided by a **Primary Plan** when, according to the rules set forth below, the **Plan** is the **Secondary Plan**. If there is more than one **Secondary Plan**, the order of benefit determination rules determine the order among the **Secondary Plans**. The **Secondary Plans** will pay up to the remaining unpaid **Allowable Expenses**, but no **Secondary Plan** will pay more than it would have paid if it had been the **Primary Plan**. The method the **Secondary Plan** uses to determine the amount to pay is set forth below in the Procedures to be followed by the Secondary Plan to Calculate Benefits section below.

Rules for the Order of Benefit Determination:

The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the person as a dependent. The coverage as an employee, member, subscriber or retiree is the **Primary Plan**.

The benefits of the **Plan** that covers the person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the **Plan** that covers the employee as a laid off or retired employee, or as such a person’s dependent. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the **Plan** that covers the person under a right of continuation pursuant to Federal or State law. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are neither separated nor divorced, the following rules apply:

- i. The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
- ii. If both parents have the same birthday, the benefits of the **Plan** which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
- iii. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- iv. If the other **Plan** contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are separated or divorced, the following rules apply:

- i. The benefits of the **Plan** of the parent with custody of the child shall be determined first.
- ii. The benefits of the **Plan** of the spouse of the parent with custody shall be determined second.
- iii. The benefits of the **Plan** of the parent without custody shall be determined last.
- iv. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that **Plan** has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the **Plan** of the other parent shall be considered as secondary. Until the entity providing coverage under the **Plan** has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which **Plan** is the **Primary Plan**, the benefits of the **Plan** that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the **Plans** that covered the person for a shorter period of time.

Procedures to be followed by the Secondary Plan to Calculate Benefits.

In order to determine which procedure to follow it is necessary to consider:

- i. the basis on which the **Primary Plan** and the **Secondary Plan** pay benefits; and
- ii. whether the provider who provides or arranges the services and supplies is in the network of either the **Primary Plan** or the **Secondary Plan**.

Benefits may be based on the **Reasonable Charge**, or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the bill charge. In this section, “Reasonable Charge Plan” means a plan that bases benefits on a **Reasonable Charge**.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a “Preferred Care Provider”, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, “Fee Schedule Plan(s)” means a Plan that bases benefits on a negotiated fee schedule. If the covered person uses the services of a non-network provider, the **Plan** will be treated as a Reasonable Charge **Plan** even though the **Plan** under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that Aetna pays the Preferred Care Provider a fixed amount per employee. The covered person is liable only for the applicable deductible, coinsurance or copayment. If the covered person uses the services of other than a Preferred Care Provider, Aetna will only pay benefits in the event of emergency care or urgent care. In this section, “Capitation Plan” means a **Plan** that pays Preferred Care Providers based upon capitation.

11554

Primary and Secondary Plans are Fee Schedule Plans

If the provider is a Preferred Care Provider in both the **Primary Plan** and the **Secondary Plan**, the **Allowable Expense** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

- i. the amount of any deductible, coinsurance or copayment required by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The total amount the provider receives from the **Primary Plan**, the **Secondary Plan** and the covered person shall not exceed the fee schedule of the **Primary Plan**. In no event shall the covered person be responsible for any payment in excess of the deductible, coinsurance or copayment of the **Secondary Plan**.

Primary Plan is Reasonable Charge Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Preferred Care Provider in the **Secondary Plan**, the **Secondary Plan** shall pay the lesser of:

- i. the difference between the amount of the billed charges for the **Allowable Charges** and the amount paid by the **Primary Plan**; or

- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The covered person shall only be liable for the deductible, coinsurance or copayment under the **Secondary Plan** if the covered person has no liability for deductible, coinsurance or copayment under the **Primary Plan** and the total payments by both the **Primary Plan** and the **Secondary Plan** are less than the providers billed charges. In no event shall the covered person be responsible for any payment in excess of the deductible, coinsurance or copayment of the **Secondary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable Charge Plan

If the provider is a Preferred Care Provider in the **Primary Plan**, the **Allowable Expense** considered by the **Secondary Plan** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

- i. the amount of any deductible, coinsurance or copayment required by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable Charge Plan or Fee Schedule Plan

If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the employee receives from a non-network provider is not considered as urgent care or emergency care, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Reasonable Charge Plan

If the covered person receives services or supplies from a provider who is a Preferred Care Provider of both the **Primary Plan** and the **Secondary Plan**, the **Secondary Plan** shall pay the lesser of:

- i. the amount of any deductible, coinsurance or copayment required by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Capitation Plan or Fee Schedule Plan or Reasonable Charge Plan and Secondary Plan is Capitation Plan

If the covered person receives services or supplies from a Preferred Care Provider of the **Secondary Plan**, the **Secondary Plan** shall be liable to pay the capitation to the Preferred Care Provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the **Primary Plan**. The covered person shall not be liable to pay any deductible, coinsurance or copayment of either the **Primary Plan** or the **Secondary Plan**.

Primary Plan is an HMO and Secondary Plan is an HMO

If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is a network provider of the **Secondary Plan**, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary and Secondary Plans are Reasonable Charge Plans

The **Secondary Plan** shall pay the lesser of:

- i. the difference between the amount of the billed charges and the amount paid by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

When the benefits of the **Secondary Plan** are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the **Plan**.

11554

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen dental coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Dental Expense Coverage on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change dental coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

Any extension of dental benefits under this Plan will not apply on or after the date of a change to an HMO Plan.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

7312

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

having refused it;

having dropped it;

having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

5090

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

6051

Appeals Procedure

The following Appeals Procedure section applies only to Group Health Coverage.

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service or supply.

Such Adverse Benefit Determination may be based on, among other things:

- The covered person's eligibility for coverage;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not Medically Necessary.

Appeal: A written request to Aetna to reconsider an Adverse Benefit Determination.

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

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."

Urgent Care Claim: Any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a dentist with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

11600

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, 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 Dentist 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.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days or the time limit established by Medicare, if earlier, after the post-service claim is made if the claim is submitted electronically, or 40 days is submitted by a means other than electronic. Aetna may determine that due to matters beyond its control a claim may require special treatment and Aetna will make notification including the reason for delay within 30 days. If this special treatment is needed because Aetna needs additional information to make a claim determination, the notice shall specifically describe the required information. In the event payment is withheld on all or a portion of the claim, because the claim requires special treatment, a claim determination will be made on the withheld portion no later than 30 calendar days or the time limit established by Medicare, if earlier, following receipt of the required documentation for claims submitted by electronic means and no later than 40 days following receipt of the required documentation for claims submitted other than electronically.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you 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 10 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. This Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

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 must be in writing and should include:

- Your name;
- Member ID on your ID card;
- 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 the address shown on the Notice of Adverse Benefit Determination, or you may call in your appeal using the toll-free number listed on such notice.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Level One Appeal – Group Health Claims

A level one appeal of an Adverse Benefit Determination shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination.

Urgent Care Claims

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

Post-Service Claims

Aetna shall issue a decision within 10 calendar days of receipt of the request for an Appeal.

Level Two Appeal

If Aetna upholds an adverse benefit determination at the first level of appeal, 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 notice of a level one Appeal.

A level two Appeal of an Adverse Benefit Determination of an Urgent Care Claim shall be provided by a professional Dental Consultant not involved in making the Adverse Benefit Determination. A level two appeal of an Adverse Benefit Determination will be reviewed by a professional Dental Consultant not involved in making the Adverse Determination.

Urgent Care Claims

Aetna shall issue a decision within 36 hours of receipt of the request for a level two Appeal.

Post-Service Claims

Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two Appeal.

11600

External Review

You or any provider acting on behalf of you, with your consent, who is dissatisfied with the result of the Level One Appeal and Level Two Appeal process above, shall have the right to pursue their appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below. The appeal review shall not include any decision regarding benefits not covered by the covered person's health benefits plan. The right to an external appeal under this section shall be contingent upon your exhaustion of both stages of the Level One and Level Two Appeal processes, except that the covered person and any provider acting on behalf of a covered person with the covered person's consent shall be relieved of the carrier's internal appeal process and may pursue an appeal through the Independent Health Care Appeals program if:

- A determination on any appeal regarding urgent or emergency care is not forthcoming from Aetna within 72 hours of receipt by Aetna of notice (in the manner required under the plan) of the appeal;
 - A determination on an initial appeal, other than one regarding urgent or emergency care, is not forthcoming from Aetna within five business days of the date that Aetna received notice (in manner required under the plan) of the appeal; or
 - A determination of a subsequent level of appeal, other than one regarding urgent or emergency care, is not forthcoming from Aetna within 20 business days of the date that Aetna received notice (in the manner required under the plan) of the appeal.
1. Within 60 calendar days from receipt of the written determination of the Level Two Appeal panel, you, or a Provider acting on behalf of you with your consent, shall file a written request with the New Jersey Department of Banking and Insurance. The request shall be filed on forms, if applicable, provided to you by Aetna and include both a filing fee and a general release executed by you for all records pertinent to the appeal. The request shall be mailed to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
20 West State Street, 9th Floor
PO Box 329
Trenton, New Jersey 08625-0360
Main Telephone Number: (609) 292-5316
Fax: (609) 292-5865

2. The fee for filing an appeal shall be \$ 25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee is payable by you. Upon a determination of financial hardship, the fee may be reduced to \$ 2.00. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance.
3. Upon receipt of the appeal, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the appeal to an IURO.
4. Upon receipt of the request for appeal from the New Jersey Department of Banking and Insurance, the IURO shall conduct a preliminary review of the appeal and accept it for processing if it determines that:
 - i. the individual was or is covered by Aetna;
 - ii. the service which is the subject of the complaint or appeal reasonably appears to be a covered benefit under the plan;
 - iii. you have fully complied with both the Level One and Level Two Appeal processes except as provided above;
 - iv. you have provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the appeal form and a copy of any information provided by Aetna regarding its decision to deny, reduce, or terminate the covered benefit, and a fully executed release to obtain any necessary records from Aetna and any other relevant health care provider; and
5. Upon completion of the preliminary review, the IURO shall immediately notify you and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefore.
6. Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of Aetna's utilization management determination, you were deprived of medically necessary covered benefits. In reaching this determination, the IURO shall take into consideration all pertinent records, consulting dentist reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by Aetna.

7. The full review referenced above shall initially be conducted by a dentist licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant dentist in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.
8. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to you, to the New Jersey Department of Banking and Insurance, and to Aetna setting forth the status of its review and the specific reasons for the delay.
9. If the IURO determines that you were deprived of medically necessary covered benefits, the IURO shall recommend to you, Aetna, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services you should receive.
10. Once the review is complete, Aetna will abide by the decision of the IURO.

For more information about the External Review process, call the toll-free Covered Person Services telephone number shown on your ID card.

General Information

- Please note that covered persons shall not be held financially liable for payments to preferred providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered services, if the carrier fails to pay for the covered services for any reason.
- Subsequent changes in this coverage shall be evidenced in a separate document issued to the covered person.

General Claim Information

Any unpaid balance on a claim will be paid within 30 days of receipt by Aetna of the due written proof. However, if the claim is not denied by Aetna for valid and proper reasons and the unpaid balance is not paid within 30 days following receipt of the claim when submitted by electronic means or 40 days following receipt of the claim when submitted by other than electronic means, Aetna will pay the insured interest on accrued benefits at the rate of 10 percent per annum.

11600, 12160-2

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the policy month after the policy month in which the absence started. The term "policy month" is defined elsewhere in the group contract. See your Employer for this definition.

The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

6080

A "Domestic Partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this Plan no longer allows coverage for Domestic Partners.

- The date of termination of Domestic Partnership. In that event, you should provide your Employer with a copy of a judgment of termination of Domestic Partnership if Domestic Partnership was established by an Affidavit of Domestic Partnership, or a completed and signed Declaration of Termination of Domestic Partnership if Domestic Partnership was established by a Declaration of Domestic Partnership.

Handicapped Dependent Children

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 a personal medical conversion policy.

11048

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; 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.

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.

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.

11048

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below.

The words "totally disabled" mean that:

- You are prevented because of injury or disease from engaging in your customary occupation and are performing no work of any kind for pay or profit.
- Your dependent is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex in good health.

6180, 11074

Comprehensive Dental Expense benefits will be available to him or her while disabled for up to 12 months. The benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 12 month period.

6180

Health Expense benefits will cease when the person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

6180

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

6450

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at Aetna's expense.

7671

Legal Action

No legal action can be brought to recover 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 a person's 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.

6470-1

Additional Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, or if you have a complaint against a provider, you may obtain more information from your Employer who may direct you to a local Aetna office. Otherwise, you may write to the following address:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156
Attention: Law Department, State Government Affairs, RW4A

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

11078

Assignments

Coverage may be assigned only with the written consent of Aetna.

6430

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

- to require the return of the overpayment on request; 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.

9352

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

6320

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

6320

If you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Otherwise, late claims will not be covered.

6320, 11022-1

Payment of Benefits

6350, 9265

Benefits will be paid as soon as the necessary proof to support the claim is received.

6350, 9265

All benefits are payable to you. However, Aetna will pay any health benefits to the service provider if you have told Aetna to do so before or when you file the claim.

6350, 9265

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

7693

Aetna may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes 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.

6350, 9265

Records of Expenses

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

Very important are:

Names of **dentists** who furnish services.

Dates expenses are incurred.

Copies of all bills and receipts.

6380

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

9990

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

Jaw Joint Disorder

This is:

- a Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint; or
- a Myofacial Pain Dysfunction (MPD); or
- any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;

- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease 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.

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Physician

This means a legally qualified physician.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

R.N.

This means a registered nurse.

Recognized Charge

Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply.

In determining the recognized charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the recognized charge in other areas.

Semiprivate Rate

This is the **charge for board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Confidentiality Notice

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

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

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

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

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your employer offers Retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to qualify for this extension you must provide a copy of your Disability Award letter that is received from the Social Security Administration prior to the end of your COBRA continuation period to the Plan administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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

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

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

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

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

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

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

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

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

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

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

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